Authorization for Disclosure of Protected Health Information

1. PATIENT INFORMATION

MRN			
LAST NAME	FIRST	MIDDLE	MAIDEN
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	DAYTIME PHONE	

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

☐ CONTINUITY OF CARE/MEDICAL TREATMENT (MINIMUM DOCUMENT SET will be submitted unless otherwise indicated below)
☐ PERSONAL USE
☐ LEGAL REASONS
☐ INSURANCE OR PAYMENT (**Please circle applicable insurance/payment purpose from the list below):**
☐ OTHER REASON **(Please Specify):** _____

3. ACCESS METHOD

SELECT A FORMAT THEN CIRCLE A DELIVERY METHOD:

☐ Fax #: _____ ☐ Email: _____
☐ Paper – Pick up at MVHC _____ (Location)
☐ Paper – Mail (Place address below in box 5.)

*If you select the email option, you hereby acknowledge and accept the inherent risk associated with an unsecured email transmission, which can place your information at risk of being read or accessed by someone else, and you agree that MVHC will not be responsible for disclosures that might occur in transit.

4. SCOPE (WHEN AND (WHERE)

Information Requested from: / / to date: / /

*If date range is not specified we will send the last 2 years of records.

SPECIFY MVHC ENTITY INFORMATION TO BE DISCLOSED FROM:

☐ STATEMENTS OF CHARGES AND PAYMENTS ☐ IMAGING REPORTS ☐ LAB RESULTS
☐ OFFICE VISITS ☐ MEDICATION LISTS ☐ IMMUNIZATIONS
☐ LIST OF VISIT DATES/APPT HISTORY ☐ DENTAL RECORDS
☐ OTHER: _____

SENSITIVE INFORMATION:

☐ SUBSTANCE ABUSE ☐ MENTAL HEALTH ☐ HIV/AIDS RELATED TESTING
☐ OTHER INFORMATION: _____

NOTE: If you do <u>not</u> indicate above your request for specific exclusion(s), information will be disclosed within the requested records, which may include HIV (Human Immunodeficiency Virus). AIDS (acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS if existing in your record to the extent permissible by state and federal law. **A <u>separate</u> authorization is <u>required</u> for the release of <u>psychotherapy</u> notes.**

5. SEND INFORMATION TO

MAIL TO ORGANIZATION/AGENCY/PERSON:		ATTN:	
ADDRESS	CITY	STATE	ZIP
PHONE #			
FAX TO:	FAX #		

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6. REQUEST NFORMATION				
REQUEST RECORDS FROM			ATTN:	
ADDRESS	CITY		STATE	ZIP
PHONE #				
FAX TO:	FAX #		☐ VERBAL EXCHANGE	

7. ACKNOWLEDGEMENT

Authorization:

- I understand that if the person or entity that receives the above information may not be a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and may no longer be protected by the federal privacy regulations.
- I understand that I am not required to sign this authorization form and that MVHC will not condition the provision of treatment or payment to me on the signing of this authorization, except that MVHC may condition the provision of research-related treatment to me on signing of this authorization for the use or disclosure of my protected health information for such research. MVHC may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.
- I understand that by signing this authorization for the purpose of research, it gives the researcher(s) the permission to use or disclose my personal health information for such research.
- I understand that my records/protected health information cannot be released pursuant to an authorization unless I sign the form.
- I may revoke this authorization at any time, except when information has already been released in reliance on my authorization, provided that any such revocation is in writing.
- A photocopy or fax of this authorization is as valid as the original
- MVHC, its directors, officers, employees, agents and volunteers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I may request a copy of this signed authorization.

Revocation: As described in the Notice of Privacy Practices of MVHC, I understand that I may revoke the authorization in writing at any time by sending a written revocation to MVHC Medical Records/2725 Pinkerton Road/Zanesville, OH 43701, and that no further release shall occur except to the extent that such action has been taken by MVHC in reliance on this authorization prior to notice of revocation.

Prohibition on Re-Disclosure: I understand this information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.

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8. EXPIRATION	This authorization for the release of protected health information for the date of service indicated is effective until ___/____/_____or, if no date is specified or if such specified date exceeds one year from the date signed below, for a period of one year from the date signed below. I hereby authorize MVHC to disclose to the party (parties) named in this document, information from my medical record as specified herein. **X Signature of Patient _____ Date_____Time _____** **Sig. of Representative/Guardian of Pt _____ Date _____Time _____** **Printed Name of Individual Authorized by Patient _____Date _____Time _____**
9. FEES	**You may be charged a fee for copies of medical records in accordance with Ohio Revised Code 3701.741. If you have question about an invoice you have received or the records release process, please contact MVHC Medical Records at 1-740-962-1668**

VERIFICATION REQUIRED BY THE SIGNER OF THIS DOCUMENT.

If you are verifying your identity via driver's license or gov't issued photo ID, please email a photo of the document to: Medical-Records@mvhealthcenters.org or text image to 740-891-9000 with a note that says ATTN: Medical Records.

FOR MVHC ONLY:

VERIFICATION IN PERSON/IN WRITING

☐ Driver's license or other government issued photo ID

☐ If no photo ID, 3 forms of identification with name:

_____

_____

_____

☐ Verified patient/parent info in Epic

☐ Verified signature against documents already on file

VERIFICATION IN PERSON/IN WRITING

☐ Billing Address ☐ Patients D.O.B. ☐ Mother's SSN ☐ Childs middle name ☐ SSN ☐ MRN # ☐ Insurance ID number