Memorial HOSPITAL

AUTHORIZATION TO RELEASE INFORMATION TO MEMORIAL HOSPITAL

Please note that each section of the form must be completed in its entirety.
Failure to specify (including dates) will delay the processing of your request.

Patient Information	Last Name	First Name	Middle Initial
	Date of Birth	Phone #	*SSN#*
	Address		
	City	State	Zip Code
Release To	**I hereby authorize _____to disclose my protected health information as indicated below TO MEMORIAL HOSPITAL:** **(Format to be: ☐ Paper ☐ CD ☐ Verbal)**		
	ATTN (Clinician Name):		
	Address: 500 London Ave Marysville, Ohio 43040		
	Information may be: ☐ Mailed ☐ Faxed (#:) ☐ Verbally Disclosed		
Information to be Disclosed	**Please tell us about the information needed for Memorial Hospital:**		
	From (date) _____	To (date) _____	
	☐ Pertinent Package (Most recent H&P, D/S, OP Note, Consult, X-Ray Report, Test Results)		
	☐ Inpatient Record	☐ Discharge Summary	☐ Operative Report
	☐ Emergency Record	☐ History & Physical	☐ Consultation Reports
	☐ Laboratory Report	☐ Clinic ***(specify):***	
	☐ Imaging Report	☐ Imaging Disk	☐ Other:
Specially Protected Information	**I understand that this protected health information may include HIV-related information and/or information relating to diagnosis or treatment or mental illness and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:**		
	☐ Substance Abuse (including alcohol/drug abuse)		☐ N/A (Not Applicable)
	☐ Mental Health		
	☐ HIV related information (including AIDS related testing and results)		
Purpose for Disclosure	**Please check purpose of disclosure to Memorial Hospital:**		
	☐ Changing provider	☐ Ongoing communication	☐ Treatment planning
	☐ Second opinion	☐ Document Review	
	☐ Continuing Care	☐ Other:	

1. I understand that this authorization will expire one year from the date of my signature below.

RELEASE OF INFORMATION FORM TO MEMORIAL HOSPITAL

2. I understand that I may shorten, extend, or revoke this authorization at any time by notifying the HIPAA Compliance Officer at the address indicated below, in writing. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.

   Mail written requests to: HIPAA Compliance Officer
   Memorial Hospital
   500 London Ave.
   Marysville, Ohio 43040

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my protected health information is required for the provision of healthcare or to obtain payment for healthcare.
5. I understand that I can request a copy of this form after I sign it.

A photocopy of this form will be considered as valid as the original.

By signing below, I affirm that I am the patient or patient's representative and have the authority to authorize who may access this patient's health information and to review and/or request changes to this patient's health information.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date/Time: _____

For Office Use Only

Verification of Identity

(Check all means of verification as applicable)

- ☐ Driver's License or other government issued picture ID
- ☐ If no picture ID, 3 forms of identification with name on them
- ☐ Verified patient/guardian in system
- ☐ Verified signature against documents already on file

Date Received/By: _____

Date Completed/By: _____