Lindner Center of HOPE | UC Health

AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print) MR # _____

Last, First, MI _____ Date of Birth _____ Social Security Number _____

Address, City, State, Zip Code _____ Phone # _____

PROTECTED HEALTH INFORMATION (PHI) TO BE OBTAINED OR DISCLOSED

Check boxes to indicate the PHI that may be obtained or disclosed:

INPATIENT Dates of Service: _____ **and/or Outpatient Dates of Service:** _____

- ☐ Outpatient Assessment
- ☐ Inpatient Assessment
- ☐ Medical History & Physical
- ☐ Psychological Testing Reports
- ☐ Itemized Billing Statement
- ☐ After Visit Summary
- ☐ Physician Orders
- ☐ Consultation Reports
- ☐ Treatment Plan
- ☐ Educational Info/Assignments
- ☐ Discharge Summary
- ☐ MRI Reports
- ☐ ECT Record
- ☐ TMS Record
- ☐ Other: _____
- ☐ Laboratory Reports
- ☐ Social Work Assessment
- ☐ Progress Notes _____
- ☐ Nursing Assessment

☐ Disclosure Records To: ☐ Obtain Information From:

Individual/Agency/Hospital _____

Address, City, State, Zip Code _____

Phone Number _____ Fax Number _____ Reason for Disclosure (ie. Medical, Attorney, Personal) _____

I, the undersigned, authorize Lindner Center of HOPE, 4075 Old Western Row Road, Mason, OH 45040 to use and/or disclose information from my medical or financial record as specified above.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include documentation of treatment for mental health disorders, alcohol/drug abuse or dependence, and/or HIV/AIDs test results or diagnosis. I expressly consent to the release of information as designated above. Furthermore, I consent to the release of the facsimile transmission of my protected health information as necessary.

This authorization will expire in six (6) months unless otherwise specified. I understand that I or my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance of this authorization. I also understand that Lindner Center of HOPE may charge a reasonable fee for the preparation, copying and postage as allowed by state law for copies of medical records. I understand that if I want to revoke this authorization that I must do so in writing and present my written revocation to: Health Information Management, Release of Information, Lindner Center of HOPE.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

I understand that if the person/entity that receives the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

Patient Signature (if 18 years of age or older) _____ Date/Time _____

Signature of ☐ Parent ☐ Legal Guardian (check one) _____ Date/Time _____

Witness _____ Date/Time _____

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other wise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Please return completed form to Health Information Management, Lindner Center of HOPE, 4075 Old Western Row Road, Mason, OH 45040. Ph. (513)536-0205 Fax (513) 536-0219.

STAFF USE

Request Has Been Fulfilled by: ☐ HIM ☐ OPP ☐ Unit ☐ Social Worker / Staff Name: _____ Initials: _____ Date/Time: _____

Sent by: ☐ Fax ☐ Mail ☐ Picked up Driver's License: _____