LINDNER CENTER OF HOPE

POLICY/PROCEDURE TITLE: *HIPAA – Access, Confidentiality and Release of Health Information*	Page 1 of 10
	Effective: 07/01/08
POLICY NUMBER: HIM-008	**Last Reviewed/Revised:** 9/17/2025
RESPONSIBLE DEPARTMENT: Health Information Management	
ADMINISTRATIVE APPROVAL: Laura Nixon, CFAO	

DEFINITIONS

I. **Disclosure:** The release, transfer, provision of access to, or divulging in any other manner of information from the entity holding the information.

II. **HIPAA:** Abbreviation for the Health Insurance Portability and Accountability Act of 1996.

III. **Protected Health Information (PHI):** PHI that is the subject of this policy is health and demographic information that is created or received by LCOH and relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient; and that identifies the patient or for which there is a reasonable basis to believe the information can be used to identify the patient. PHI includes information of persons living or deceased. The following components of a patient's information are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to an patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) internet protocol (IP) address numbers; n) biometric identifiers, including finger and voice prints; o) full face photographic images and any comparable images; and p) any other unique identifying number, characteristic, or code.

IV. **The Health Insurance Portability and Accountability Act of 1996:** Standards for Privacy of Individually Identifiable Health Information; Final Rule 45 CFR Parts 160 and 164. This rule includes standards to protect the privacy of individually identifiable health information and is effective April 14, 2003.

V. **Use.** With respect to PHI, the sharing, employment, application, utilization, examination, or analysis of information within the entity that maintains such information.

VI. **Workforce Members:** Employees, volunteers, trainees, and other persons whose work performance for LCOH come under the direct control of the LCOH whether or not paid by LCOH.

VII. **Patient Representative**: refers to an individual who is legally authorized to act on behalf of the patient in matters related to their healthcare and access to protected health information (PHI). This may include a **legal guardian**, a **holder of a valid healthcare power of attorney (POA)**, or any other individual with appropriate legal documentation confirming their authority.

VIII. **EMR:** Electronic Medical Record

POLICY

I. Access to Protected Health Information (PHI)

A. Lindner Center of HOPE (LCOH) maintains an electronic medical record. LCOH employees have access to the electronic medical record according to the employee's job function and access level (refer to IM-Information Security and Data Integrity Policy).

B. Request for Access or Copy of Patient's Medical Record.

1. A patient, or the patient's personal representative, may request to review or obtain a copy of the patient's PHI upon written request and with reasonable notice. The Lindner Center of HOPE (LCOH) form titled: "Authorization for the Release of Patient Protected Health Information" may be utilized as the written request. This request may be denied by the attending physician/primary therapist if disclosure is not in the patient's interest and is also subject to any legal constraints, such as those limiting the patient's right of access to psychotherapy notes, information compiled in reasonable anticipation of a civil, criminal or administrative proceeding, or certain information subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988 and those governing minors and those adjudicated as incompetent. The reason for denial will be noted by the attending physician/primary therapist in the medical record (Ohio Revised Code (ORC) 5122.31).

a. The "Authorization for the Release of Patient Protected Health Information" cannot be altered once signed by the patient or patient representative.

b. If access is denied, a written statement must be given to the patient or patient representative.

c. The statement of denial must explain the basis of denial, how the denial can be reviewed by Lindner Center of HOPE (LCOH) and how the individual may make a complaint to the LCOH Privacy Officer.

2. Any request from a patient or his/her family to inspect the patient's PHI will be referred to his/her attending physician/primary therapist. Patients are permitted to review their own PHI, unless access is restricted for treatment reasons. The physician or therapist will document in the medical record the reason access is restricted.

3. Minor of divorced parents: both residential and "non-residential" parents have equal access to child's record, with the exception that the residential parent objects and a court determines that disclosure to non-residential parent would not be in the child's best interest. Then a court journal entry will be required to verify that the non-residential parent cannot have access to the record. The HIM staff will verify which parent has access based on record review and court documentation.

C. Third Party Requests for Access or Copies of Patient's PHI

1. PHI maintained by a mental health hospital or inpatient unit of a hospital designated as a mental health unit may be disclosed to the following outside persons or entities:
   a. To the patient, unless access is restricted for treatment reasons, as indicated in Section I. A above.
   b. Based on patient Authorization (if it is in the patient's best interest).
   c. To insurers to obtain payment for goods and services provided to the patient.
   d. Pursuant to a court order.
   e. To a family member who is involved in the provision and planning of a patient's treatment (if it is in the patient's best interest and the patient is notified and does not object).
   f. To a prosecuting attorney if treatment is based on criminal commitment, or to a board of mental health services if treatment is based on voluntary commitment.
   g. To the Department of Mental Health for quality review (however, the patient's name should be excluded).

2. Substance abuse records can be disclosed to third parties if the patient signs an Authorization and the Authorization specifically identifies the person or entity to whom the information is to be provided and describes with reasonable specificity the PHI to be disclosed, the purposes of the disclosure, and the intended use of the disclosed PHI.

   In addition, substance abuse records can be disclosed to third parties without patient Authorization:
   a. If the patient participates in a drug/alcohol treatment program as a condition of parole, probation, or court order permitting treatment instead of conviction (O.R.C. §3793.13(C)).
   b. Where research, management, financial audits, or program evaluation will be conducted on a patient-anonymous basis (O.R.C. §3793.13(D)).
   c. Where a court has ordered disclosure to a prosecutor or director mental health (O.R.C. §3793.13(E)).
   d. To outside medical personnel for bona fide medical emergencies.

3. Healthcare workers and State agencies are prohibited from disclosing the following information to outside persons or entities without appropriate Authorization and this law will take precedence over HIPAA which may allow such disclosures:
   a. The identity of an individual tested for HIV.
   b. The results of an HIV test (unless test results are anonymous).
   c. The identity of any individual diagnosed with AIDS or an AIDS-related condition. (O.R.C. §3701.243(A)).

4. Disclosure of a patient's HIV test results is permitted in certain circumstances. Note that Ohio law allows certain permitted disclosures which are not listed here because these disclosures would be preempted by HIPAA. The following are consistent with both Ohio law and HIPAA:
   a. To the patient or the patient's legal guardian.
   b. To the patient's physician for treatment.
   c. To any person authorized by the patient in writing.
   d. To the Department of Health when reporting a communicable disease as required by law.
   e. To transplant facilities when the deceased individual was a donor.
   f. To accreditation or oversight review committees who conduct program monitoring, evaluation, or service reviews.
   g. To a healthcare provider, emergency medical services worker, or peace officer who has sustained significant exposure to bodily fluids for purposes of testing the recipient of the information. Only the fact that the test was given, the results, and any diagnosis of AIDS or AIDS-related conditions may be disclosed but not patient identifying information. (May be preempted by HIPAA; check with legal counsel before making a disclosure pursuant to this section).
   h. To law enforcement agencies pursuant to a search warrant or subpoena in a criminal investigation.
   i. To individuals involved in diagnosis or treatment and such information is needed to treat the patient if there is a "medical need to know."
   j. To appropriate government agencies for the purpose of federal, state, or local public assistance programs such as Medicare and Medicaid.
   k. To emergency care workers who have been exposed to bodily fluids (may be preempted by HIPAA but HIPAA does allow certain disclosures when there is a threat to health or safety; before making any disclosures under this section, check with legal counsel).
   l. Pursuant to a court order in some circumstances. (O.R.C. §3701.243(B))

4. Physicians/therapists may not give authorization to third parties such as attorneys to secure a patient's medical records. The patient or the patient's representative must provide a signed Authorization authorizing disclosure to third parties.
5. Physicians, nurses, or other related professional persons, not on the staff of LCOH, who desire to see PHI, must obtain patient Authorization. No employee is to assume that merely because the requestor is a physician/clinician, he/she has more right than a non-physician/clinician to obtain PHI. Every effort will be made to provide the outside physician with the PHI he/she requires in a timely manner consistent with the patient's Authorization.
6. When a patient is transferred to another healthcare facility, in an emergency or non-emergency situation, a copy of the appropriate portions of the PHI will accompany the patient. Any PHI needed after the transfer will require a signed Authorization. (See Assessment, Stabilization and Treatment policy in Patient Care)
7. The "Authorization for the Release of Patient Protected Health Information" form (attached) will also be used to obtain permission from the patient or responsible individual for LCOH to request information from other facilities.

8. The fact that an employer has paid or has agreed to pay LCOH's charges on an employee, does not authorize LCOH to release to the employer confidential information without a signed Authorization form from the patient or the patient's legal representative.

9. When properly identified law enforcement agents (e.g., F.B.I., police) present themselves, PHI will not be disclosed without a written presentation of certification of a pending investigation or court order (O.R.C. 2305.24, 2305.25 and 2305.251).
10. The Quality and Compliance Coordinator should be notified whenever a request for PHI indicates there may be legal action brought regarding LCOH.

II. Verbal Communication

A. A patient, or the patient's personal representative, may authorize LCOH employees to speak with designated individuals/organizations about the patient's treatment.

1. An "Authorization for Verbal Communication to Share Patient Protected Health Information" form must be fully complete by the patient or the patient's representative before LCOH staff are able to disclose patient information.
2. Verbal communication includes speaking in person, via phone, or via email (for non-urgent communication, sent encrypted).
3. The verbal communication authorization does not allow LCOH staff to share medical records.
4. A signed authorization for verbal communication is valid for up to 12 months.
5. The signed authorization form for Verbal Communication will be kept in the EMR.
6. This form cannot be altered once signed by the patient or patient representative.
7. The patient has the right to revoke this authorization at any time (See policy HIM-019 "***HIPAA/HITECH – Restrictions on Uses and Disclosures of Patient Protected Health Information" for revocation policy/procedure).***

III. Disclosures of Patient Medical Information REQUIRED to be Disclosed.

A. The following medical information is required to be disclosed.

1. Physicians and other healthcare providers are required to report to law enforcement any gunshot or stab wound that the provider treated or observed, or any other serious physical harm that the provider reasonably believes resulted from a violent offense. (O.R.C. §2921.22)

2. Physicians and other healthcare providers are required to report any suspected cases of child abuse to a public children services agency or to law enforcement. (O.R.C. §2151.421)

3. Physicians and other healthcare providers are required to report any suspected cases of abuse, neglect, or exploitation of an adult (person 60 years old or older) to the county department of job and family services. (O.R.C. §5101.61)

4. A provider who provides treatment to an injured employee must report the employee's injury to the Managed Care Organization responsible for payment to the provider. (Ohio Administrative Code (O.A.C) §4123-6-028)

5. Law enforcement authorities may obtain copies of any records related to any drug or alcohol test administered to a person to determine the presence of alcohol or drugs in the person's system at any time relevant to the criminal offense in question. (O.R.C. §2317.022) There is a specific form found in O. R.C. §2317.022 that law enforcement must execute and present to the provider to obtain testing results.

IV. General Guidelines Regarding Confidentiality of Medical Records

A. All information in the medical record will be confidential and only disclosed for purposes of treatment, payment and operations (as defined in HIPAA), pursuant to a proper written Authorization or court order and appropriate regulatory agency compliance survey. Reasonable attempts will be made to limit the use and/or disclosure of PHI to the amount that is minimally necessary to accomplish the intended purpose of the use and/or disclosure.

1. PHI regarding a patient is strictly confidential and no part of the patient's PHI may be revealed over the telephone or in person without the patient's previous knowledge and written Authorization, except as permitted in Sections I and II above.

2. PHI concerning previous admission(s) is also strictly confidential and cannot be revealed to anyone without the patient's previous knowledge and written Authorization, except as permitted in Sections I and II above.

3. LCOH employees will not convey to a person outside of LCOH that a patient attends or receives services from LCOH or disclose any information identifying a patient, as psychiatric, an alcohol or other drug services patient unless the patient consents in writing for the release of information or the disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes. (O.A.C. 3793:2-1- 06(D)(1)), or as otherwise permitted in Sections I and II above.

4. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a patient either at LCOH or against any person who works for LCOH. (O.A.C. 3793:2-1-06(D)(2)).

5. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities (O.A.C. 3793:2-1-06(D)(3)), and about an individual whom LCOH believes to be a victim of abuse, neglect or domestic violence to a government authority authorized to receive such reports to the extent required by law, or if the patient agrees to the disclosure, and LCOH believes the disclosure is necessary to prevent serious harm to the patient or others. PHI may be disclosed only if it will not be used against the patient.

NOTE: The only exception to these cases is a bona fide emergency when it would be in the patient's best interest to furnish background information, such as if the patient is incapacitated and disclosure of PHI is necessary to avoid imminent adverse material consequences such that waiting until the individual can agree is not possible.

B. Medical records are available for use within LCOH for direct patient care by all authorized personnel involved in the LCOH patient's care.

C. Patient information will be obtained and discussed only in areas where the patient's right to privacy can be maintained.

D. All LCOH employees are required to maintain the confidentiality of the patient's medical record. Failure to do so will result in sanctions under the Standards of Conduct policy in Human Resources.

V. Requests For Information

A. All requests for medical records of patients admitted to LCOH will be directed to the Health Information Management Department.

B. Release of information from the medical record is carried out in accordance with all applicable legal, accrediting, or regulatory agency requirements, and in accordance with LCOH policies and procedures.

C. Release of information regarding treatment of substance abuse, psychiatric/psychological/mental disorder and HIV/AIDS **must be accompanied by an informed consent** (42 U.S.C. 29odd and ee-3; O.R.C. 5122.31; O.R.C. 3793.13).

An ***informed consent*** is a signed HIPAA Authorization that specifically acknowledges the inclusion of this information for release.

D. The requestor's identity will be verified by signature or other applicable documentation

VI. Release of Information

A. Authorization for the release of information must be obtained using the "Authorization for the Release of Patient Protected Health Information" form (attached) or through a written statement from the patient.

B. The "Authorization for the Release of Patient Protected Health Information" form may not be combined with any other document with the exception of authorization for research that involves treatment, which may be combined with the informed consent for the research study and except for an authorization for psychotherapy notes, which may be combined with another authorization for psychotherapy notes.

C. The patient should be advised to read the Authorization (or it can be read to him/her) prior to signing.

The date of the patient's signature must be dated on or after the dates of treatment. No treatment information is released past the date on the authorization (i.e., cannot authorize discloser for future treatment services that have not been provided.)

D. A signed Authorization for the Release of Information is valid for up to 12 months unless revoked by patient or patient representative

E. LCOH may release PHI upon receipt of a court order signed by a judge.

1. A court order is a document signed by a judge setting forth a judge's decision on a particular manner.
2. LCOH must comply with a properly executed court order. A court order supersedes a patient Authorization.

F. LCOH may release PHI upon receipt of a valid subpoena:

1. In response to a subpoena or discovery request issued by a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order.
2. In response to a subpoena or discovery request that is not accompanied by an order of a court or administrative tribunal, if the covered entity receives a written statement and accompanying documentation demonstrating that either of the following has occurred:
   a. The party requesting the information has made a good faith attempt to provide written notice to the individual and the notice includes sufficient information about the litigation or proceeding for which the information is requested to permit the individual to raise an objection to the court or administrative tribunal; and the time for the individual to object has lapsed and no objections were filed or all objections have been resolved by the court or administrative tribunal, (or the subpoena is accompanied by a valid patient Authorization); or
   b. The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal; or the party seeking the information has requested a qualified protective order from the court or administrative tribunal.

NOTE: Arrangements should be made with the attorney or the court to submit a photocopy of the record. If by court order, this is absolutely not possible, a copy of the record must be retained in the Health Information Management Department.

G. In accordance with federal Regulation 42 Part 2, drug and alcohol record information received from outside the hospital cannot be re-released or re-disclosed. Inquiries regarding such documents will be directed to the person or institution that originated such document. Each disclosure made with the patient's written consent must be consistent with 42 C.F.R., Part 2, by including the following written statement: Federal law 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.

VII. Copying Fees

A. The following requestors are charged for copies of records according to ORC 3701-742 rates.
   1. Attorneys.
   2. Insurance Companies (if not for reimbursement purposes).
   3. State Agencies (including Workers Compensation).

B. LCOH shall provide one copy without charge to the following:
   1. The patient
   1. The Bureau of Workers' Compensation,
   2. The Industrial Commission
   3. The Department of Job and Family Services
   4. The Attorney General

C. The Bureau of Disability Determination pays a flat $15 fee for requests.

PROCEDURE

I. Requests for copies of Medical Records

A. Validate the Authorization:
1. Check patient's age – If patient is 18 or older the authorization must be signed by the patient or patient representative. If the patient is under 18 the authorization must be signed by parent or guardian.
2. Compare the signature on the Authorization with the signature on the voluntary form/consent to treat.
   a. If the signatures are different, call the patient to get verbal authorization or return the request.
   b. Document date and time the patient gave the verbal authorization and sign it.
3. Check the Authorization date. Authorization date must occur after the treatment date. Authorization date is valid for 12 months.
4. Verify dates of records requested corresponding with actual visit date.

B. If the Authorization is invalid, the request is returned to the sender with an explanation of why the request cannot be accepted (see attachment).

C. The authorization cannot be altered by the patient, patient representative, or LCOH staff once signed.

D. If the Authorization is valid, the request will be logged in Epic module by the HIM staff.

E. Look up patient in all EMR systems according to dates of service being requested.

F. Obtain the correct episode of care.

G. Ensure that the medical record is complete. For subpoenas and court orders the medical record must be complete. Contact any physicians/clinician that have deficiencies and have them completed immediately.

H. Prior to releasing any documentation, ensure that none of the notes have been marked as blocked by the original author.
1. If the release request includes notes that are blocked, the note author must be promptly notified to determine whether the notes may be disclosed or should remain restricted from the patient.
2. In cases where the note author decides the notes should remain blocked, the release must include a formal statement from the author specifying the reason for maintaining the restriction.

I. Obtain the appropriate information from the electronic medical record:
1. Verify the name and additional information within the record (i.e. date of birth);
2. Release only LCOH medical record documents – do not release any court papers, living will, or copies of records from other facilities.

J. Record in the EMR module what information is sent and date sent.

K. Release the requested documents along with a copy of the signed Authorization Form. Requested records should be sent according to method selected on authorization form.

The original request, with the Authorization shall be scanned into document imaging in the EMR by HIM staff.

II. Subpoenas and Court Order

A. Subpoena must be accompanied by an authorization signed by the patient or legal representative or court order.

B. After validation of court order, follow procedure above.

C. Certify the printed hard copy of the record by completing the Certification Letter (attached) and having it notarized.

D. If the Subpoena or Court Order instructs the record to be mailed instead of appearing in court, prepare two envelopes such:

1. Outside envelope address to where it is to be sent.

2. The inside envelope, in which will contain the photocopied record, will have the requestor's name, title of action, date of subpoena/court order, and mark it CONFIDENTIAL INFORMATION.

3. Send it certified mail.

III. Emergency Release

A. Authorization should be secured whenever possible.

B. When Authorization cannot be secured, verify the caller.

1. Verification can be obtained by referring to the facility's telephone directory, calling the intake department to verify the person is on staff, or by calling the requestor back.

C. After Authorization/verification is obtained, the release of information may be done by the HIM Manager, Revenue Cycle Director or Administrative Supervisor.

D. A notation should be made in the patient's chart recording the date, time, circumstances, and the information given to the requestor.

E. The requesting person's name, title, and telephone number should also be recorded as well as the organization s/he represents.

F. In the absence of the HIM Manager, Revenue Cycle Director, the Administrative Supervisor or Administrative Shift Coordinator may give out the information.

IV. Verbal Communication

A. The patient or the patient's representative must complete in full the "Authorization for Verbal Communication to Share Patient Protected Health Information" form.

B. Validate the Authorization:

1. Check patient's age – If patient is 18 or older the authorization must be signed by the patient or patient representative. If the patient is under 18 the authorization must be signed by parent or guardian.

2. Compare the signature on the Authorization with the signature on the voluntary form/consent to treat.

a. If the signatures are different, call the patient to get verbal authorization or return the request.

C. Document date and time the patient gave the verbal authorization and sign it. The authorization forms cannot be altered by the patient or LCOH staff once signed.

D. If the patient is unable to sign the authorization form but verbally authorizes consent to share PHI, two witnesses must sign the "Witness" line on the verbal communication authorization form.
   1. If the patient or patient representative is able to sign, then no witness signature is required.

E. The completed form must be sent directly to the HIM department

F. HIM staff will scan the form into the patient's chart
   1. The form can be found in the "Media tab" in Chart Review.
   2. The form must be entered under document type "Verbal Authorization – Scan".

G. Verbal Communication
   1. LCOH staff may communicate with designated individuals/organizations via phone, in-person communication, or email.
   2. Email communication should be for non-urgent communication only and never include medical records.
      a. Non-Urgent Communication includes:
      - Blank forms to be completed
      - Treatment updates (excluding notes or documentation from the EMR)
      - Completed FMLA/STD forms
      - Work/School notes
   3. Verbal communication does not allow staff to send medical records, After Visit Summaries, or Discharge Instructions. (To release this information follow section I)

ATTACHMENT

AUTHORIZATION for the RELEASE of PATIENT PROTECTED HEALTH INFORMATION FORM
RETURN TO REQUESTOR LETTER
CERTIFICATION LETTER

EFFECTIVE: 7-1-08
REVIEW/REVISED: 6-08-09, 7-27-09, 12-14-09, 5-23-11, 5/14/14, 7/25/17, 3/19/2020, 2/15/23, 9/17/2025

LINDNER CENTER OF HOPE

MR# _____

Note: Please complete all 7 sections of this form.

AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

① Patient Information

DOB	Last Name	First Name	Middle Name

Address, City, State, Zip Code

E-Mail | Phone #

② Information to Release

Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified.

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

- ☐ Inpatient/Residential Records
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Outpatient Records
- ☐ PHP Records
- ☐ ECT/TMS Record
- ☐ Psychological Testing Reports
- ☐ Lab Reports
- ☐ Other Records, please specify: _____

③ Purpose

Records are to be released for the following purpose(s): (please select all that apply)

☐ Continuity of Care — OPTIONAL → My appointment date is: _____

☐ Disability/SSI ☐ Insurance ☐ Personal ☐ Attorney/Legal ☐ Education ☐ Military ☐ Other: _____

④ Disclose/Obtain Records

☐ Disclose Records To: ☐ Obtain Information From:

Individual/Agency/Hospital | Phone #

Address, City, State, Zip Code

Fax Number _____ E-Mail _____

⑤ Disclosure Method

Records are to be released in the following method: (please select 1 method)

☐ Fax ☐ Secure E-Mail ☐ U.S. Mail ☐ In Person

* NOTE: If you choose to pick up records in person, photo identification is required.

Notice to Recipients of Medical Records:

42 CFR Part 2 prohibits unauthorized disclosure of these records.

⑥ Patient/Legal Guardian Signature

I, the undersigned, authorize LCOH/LCOHPA, to use and/or disclose information from my medical or financial record as specified above. This authorization will expire in twelve (12) months unless otherwise specified on the following date (optional) _____. 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. 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 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 information is not a health care provider/ health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

_____ _____

Patient ☐ Guardian ☐ Legal Representative Signature — Date

⑦ Submit

Verify that all sections are completed in full and that the form is signed and dated. Upon completion, please do one of the following:

Mail the completed form via US Mail to:

Lindner Center of HOPE
Attention Medical Records
4075 Old Western Row Road
Mason, Ohio 45040

Fax the Form to:

(513) 536-0219

E-mail the Form to:

patient.records@lindnercenter.org

Request Has Been Fulfilled by: HIM ☐ OP ☐ Unit ☐ Date: _____ Initials _____

LINDNER CENTER OF HOPE

AUTHORIZATION FOR VERBAL COMMUNICATION TO SHARE PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print)

Last, First, MI _____ Date of Birth _____ Medical Record # _____

PROTECTED HEALTH INFORMATION (PHI) TO BE VERBALLY OBTAINED OR DISCLOSED

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

To better treat you as a patient of Lindner Center of Hope, it may be necessary to communicate and collaborate with other health care providers or family members.

I authorize Lindner Center of Hope staff to verbally share my protected health information and my billing/financial services information with those individuals listed.

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

_____

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

_____

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

_____

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 twelve (12) 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 (2 Witness signatures required if patient is unable to sign) 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.

Lindner Center of HOPE | UC Health.

DATE: _____ **RE:** _____

____ Enclosed is an authorization to release information for the above named patient. Please provide copies as identified on the release and return them within 7 business days.

____ Enclosed are copies of the information you requested on the above-mentioned patient.

____ Enclosed is a copy of the Lindner Center of Hope authorization. Please make sure that **all sections are completed** including specific dates of service you wish to have released. The patient or parent/legal guardian must sign the release.

We are unable to release the information requested for the following reason(s):

____ We require a valid, signed and dated authorization from the patient or legal guardian prior to release of records.

____ The release must specifically address mental health disorders, alcohol/drug abuse, & HIV/AIDS.

------- The above-mentioned person has not received treatment from our facility.

____ This patient received treatment by Cincinnati Children's Hospital Medical Center Adolescent Unit at LCOH. The records belong to CCHMC.

____ It is our policy not to accept an authorization dated and signed prior to the treatment date.

____ As soon as the record is completed, copies will be sent to you.

____ A Durable General Power of Attorney does not provide a means for a named agent to act as the patient's "personal representative", as defined by HIPAA, and access the requested patient health information.

____ It is our policy to only accept authorizations signed by the patient or his/her legal guardian. Please furnish proof of guardianship, if applicable.

____ We do not accept authorizations more than twelve (12) months old.

____ The above-mentioned person is no longer a current patient at LCOH. Provider has declined to complete the attached form.

Sincerely,

Lindner Center of HOPE
Health Information Management Department

Phone (513)536-0205 Fax (513)536-0219

Certification of Medical Records

Taylor White, RHIA
_____, being first duly sworn, says that she is employed as the

__HIM Manager_____ at Lindner Center of HOPE. Affiant has examined the # pages attached hereto and certifies: 1) said attachments are all exact copies of records of this hospital of which affiant is the custodian; 2) the originals of said attachments were all prepared in the usual course of the business of said hospital; 3) the originals of said attachments were all prepared at or about the time of the events and conditions they recorded; 4) the originals of said attachments were all prepared and maintained by physicians and employees of said hospital in the normal and usual manner that patients' medical records are prepared and maintained; and 5) said attachments constitute exact copies of the medical records in the custody and possession of this hospital regarding:

_____

_____

Taylor White, RHIA
HIM Manager

State of_____ County of_____

SWORN TO BEFORE ME and subscribed in my presence this _____ day of

_____, 20____.

_____

Notary Public