

Note: Please complete all 7 sections of this form.

**AUTHORIZATION FOR THE RELEASE OF
PATIENT PROTECTED HEALTH INFORMATION**

1	DOB	Last Name	First Name	Middle Name		
Patient Information	Address, City, State, Zip Code					
	E-Mail		Phone #			
	2 Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified.					
Information to Release	INPATIENT Dates of Service: _____ and/or OUTPATIENT Dates of Service: _____					
	<input type="checkbox"/> Inpatient/Residential Records	<input type="checkbox"/> Outpatient Records	<input type="checkbox"/> Psychological Testing Reports			
	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> PHP Records	<input type="checkbox"/> Lab Reports			
	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> ECT/TMS Record	<input type="checkbox"/> Other Records, please specify: _____			
3	Records are to be released for the following purpose(s): (please select all that apply)					
	<input type="checkbox"/> Continuity of Care	OPTIONAL → My appointment date is: _____				
	<input type="checkbox"/> Disability/SSI	<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal	<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Education	<input type="checkbox"/> Military
4	<input type="checkbox"/> Disclose Records To:		<input type="checkbox"/> Obtain Information From:			
	Individual/Agency/Hospital		Phone #			
	Address, City, State, Zip Code					
	Fax Number _____		E-Mail _____			
5	Records are to be released in the following method: (please select 1 method)			Notice to Recipients of Medical Records: 42 CFR Part 2 prohibits unauthorized disclosure of these records.		
	<input type="checkbox"/> Fax	<input type="checkbox"/> Secure E-Mail	<input type="checkbox"/> U.S. Mail		<input type="checkbox"/> MyChart*	
	*Must have active LCOH MyChart Account					
6	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.					
	<input type="checkbox"/> Patient <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative Signature			Date _____		
	7 Verify that all sections are completed in full and that the form is signed and dated. Upon completion, please do one of the following:					
Submit	Mail the completed form via US Mail to:		Fax the Form to:	E-mail the Form to:		
	Lindner Center of HOPE		(513) 536-0219	patient.records@lindnercenter.org		
	Attention Medical Records					
4075 Old Western Row Road						
Mason, Ohio 45040						