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 _____