

Ohio Orthopedic Center of Excellence
Authorization to Disclose Health Information

Reviewed by _____
Date _____

Patient Name: _____ Contact Number _____

Date of Birth: _____ Physician you see at OOCE _____

1. I authorize the following organization, Ohio Orthopedic Center of Excellence, located at 4605 Sawmill Road, Upper Arlington OH 43220 to make use of and disclose my health information as described below:

2. Health Record Information (Please check the appropriate box)

To be Picked up by patient Date: _____

To be disclosed and mailed to the following individual or organization:

Name: _____ Address: _____

City, State and Zip

3. Reason for records request:

Doctor appointment (no charge)

Personal record keeping (there is a charge for this)

Up to 10 pages \$2.74 per page, pages 11-50 \$.57 per page, pages more than 51 \$.23 per page

There rates are in accordance with Ohio House Bill 3701.742 and meet HIPAA guidelines

Other _____ (there may be a charge)

4. Check the type and amount of information to be used or disclosed is as follows and include dates or date range.

History and physical from (date) _____ to (date) _____

Operative report from (date) _____ to (date) _____

Labs from (date) _____ to (date) _____

MRI and X-ray **reports** from (date) _____ to (date) _____

MRI and X-ray **images** on CD from (date) _____ to (date) _____

Physical Therapy notes from (date) _____ to (date) _____

Consultation reports from (date) _____ to (date) _____

Entire record

Other _____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information department (medical records). I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I do not specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I may contact the Privacy officer @ 614-827-8700.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness