THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University
Authorization for Release of Medical Record Information

******* PLEASE RETURN THIS RELEASE FORM WITH RECORDS*******

Patient Name_____ Date of Birth_____

Telephone Number_____ Medical Record Number_____

I hereby authorize Ohio State University Physicians, Inc. to:

Check one: ○ Release my medical information to: ○ Obtain my medical records from:

Name:_____

Address: _____

_____

_____

Check one: ○ Release my medical information to: ○ Obtain my medical records from:

○ OSU Internal Medicine at Morehouse
2050 Kenny Road, Suite 2400
Columbus, OH 43221
Phone :(614) 293-8054
Fax: (614) 293-4890

○ OSU Internal Medicine at Stoneridge
3900 Stoneridge Lane
Columbus, OH 43017
Phone :(614) 293-0080
Fax :(614) 293-0077

○ OSU Internal Medicine & Pediatrics at Grandview
895 Yard Street
Columbus, OH 43212
Phone :(614)
293-7980 Fax: (614)
293-7981

○ OSU Internal Medicine at CarePoint East
543 Taylor Ave.
Columbus, OH 43203
Phone :(614) 688-6470
Fax: (614) 388-6471

○ OSU Internal Medicine at Hilliard
3691 Ridge Mill Drive
Columbus, OH 43026
Phone :(614) 688-9220
Fax :(614)688-9177

○ OSU Internal Medicine at CarePoint at Lewis Center
6515 Pullman Drive, Suite 2200
Columbus, OH 43025
Phone :(614) 688-7150
Fax: (614) 688-7155

○ OSU Internal Medicine at Upper Arlington
1800 Zollinger Rd.
Columbus, OH 43221
Phone :(614) 293-2130
Fax: (614) 293-3087

The following medical Information regarding my care and/or treatment on the following dates:

Dates: (Required)_____or_____

☐ All Records ☐ History and Physical Only ☐ Laboratory Reports ☐ Colonoscopy

☐ Radiology Reports ☐ EKG Reports ☐ Psychiatric Tests ☐ Pap Smear

☐ Mammogram ☐ Immunizations ☐ Other, please specify: _____

This Authorization also specifically includes the release of records relating to the following (if any):

☐ Diagnosis and/or treatment for alcohol and/or drug abuse** ☐ HIV test results

☐ AIDS/AIDS Related Complex diagnoses *and for* treatment ☐ Diagnosis and/or treatment relating to mental health

Purpose of Disclosure:

○ Transfer of care ○ Other, please specify_____

I understand and acknowledge that this Authorization extends to all or part of the records designated above. *A* ***separate authorization*** **is** ***required for the release of psychotherapy*** **notes or** ***for the release of medical Information for research*** **purposes**. I understand that I may revoke this Authorization at any time after I have signed it by providing OSUP with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my medical information can no longer be disclosed pursuant to this Authorization except to the extent that disclosures have already been made in reliance upon this Authorization.

Authorization is valid for one year, unless an earlier date or condition/event Is specified here:_____or unless revoked by me in writing before the release of the above designated information.

_____ _____

Signature of Patient (or Patient Representative) Date

•1f this Authorization is signed by a legal representative of the patient (for example, the parent *or* legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, <u>also</u> attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.

_____

(Relationship to Patient)

**For records covered by 42 CFR Part 2: 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 this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other 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.