Authorization for Disclosure of Health Information

1. Patient Information	City:	State:
Name:		
	Phone Number:	Date of Birth:
Address:		

2. Release Information From:	3. Release Information to:
Healthcare Provider: _____ _____ Address: _____ City: _____ State_____ Zip_____ Phone: _____ Fax: _____	**Ohio Hills Health Services** **C/O Medical Records** **101 East Main Street** **Barnesville, Ohio 43713** **Phone: 740-239-6447** **Fax: 740-425-4076**

Purpose of the disclosure: Continuity of Care

Date of service: (FROM): _____ (TO)_____

___ Office Visit	___ History and Physical	___ PT/OT Reports
___ ER Reports	___ Cardiac Reports	___ Homecare Reports
___ Discharge Summary	___ Lab Report	___ Radiation/Oncology Reports
___ Operative Reports	___ Radiology Reports	___ Mammogram report
___ Colonoscopy/Sigmoidoscopy	___ Pap testing report	

___ Other: _____

I, the undersigned authorize _____ to release health information as indicated/described above. I understand and acknowledge that the requested health information regarding physical and mental illness. HIV tests results or diagnosis, treatment for AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. *Release of Psychotherapy Notes require a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative through written notice. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, and eligibility for benefits will not be based on whether I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

_____

Signature of patient/legal representative

_____

Print Name

_____

Relationship, if not patient Date Signed

***Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record**