I, the undersigned, authorize The MetroHealth System to release health information as indicated above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

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 presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization.

(continued on back)
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 as per Ohio Revised Code 3701.741. There is no charge to send records directly to my health care provider for continuing care purposes.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

__________________________________________ / ________________________________  _____________
Signature of Patient/Patient’s Personal Representative**    Printed Name                                            Date Signed

_____________________________________________
Relationship, if not Patient

*If other than the patient’s signature, a copy of legal paperwork verifying the patient’s personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.

*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.

*For patients receiving addiction services treatment: MetroHealth provides this statement with each disclosure made with your consent: “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 disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the 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.”

Submit completed authorization to one of the following:

1. The MetroHealth System
   Health Information Management Department – G-108
   2500 MetroHealth Dr.
   Cleveland, Ohio 44109

2. Fax: (216) 778-2413

3. Additional Authorization Forms and Ohio fee schedule for medical record copies can be found at: https://www.metrohealth.org/requesting-copies-of-medical-records or call Release of Information (216) 778-4252