



## AUTHORIZATION TO RELEASE HEALTH INFORMATION

<b>1. PATIENT INFORMATION</b>	LAST NAME	FIRST	MIDDLE	MAIDEN / OTHER NAME(S)	METROHEALTH MEDICAL RECORD #
	CURRENT ADDRESS		CITY	STATE	ZIP
	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY #	PHONE # (        )		EMAIL ADDRESS
<b>2. REASON NEEDED</b>	<b>PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:</b>				
	<input type="checkbox"/> MEDICAL TREATMENT <input type="checkbox"/> PERSONAL <input type="checkbox"/> DISABILITY <input type="checkbox"/> OTHER: (please specify) _____ <input type="checkbox"/> INSURANCE <input type="checkbox"/> LEGAL				
<b>3. INFORMATION NEEDED</b>	<b>INFORMATION TO BE DISCLOSED FROM (check as applicable):</b>				
	<input type="checkbox"/> THE METROHEALTH SYSTEM <input type="checkbox"/> METROHEALTH RECOVERY RESOURCES <input type="checkbox"/> SPRY <input type="checkbox"/> OTHER: (please describe) _____				
<b>4. ACTIONS TO TAKE</b>	<b>RELEASE INFORMATION TO:</b>				
	NAME OF RECIPIENT				
<b>4. ACTIONS TO TAKE</b>	ADDRESS		CITY/STATE	ZIP	
	PHONE NUMBER (        )		FAX NUMBER (        )		
	<b>INFORMATION SHOULD BE DELIVERED ON (select one):</b>				
	<input type="checkbox"/> Release to MyChart <input type="checkbox"/> Compact Disc (CD) <input type="checkbox"/> Secure Electronic Delivery (If electronic, provide recipient's email) <input type="checkbox"/> Fax <input type="checkbox"/> Mail to the above address <input type="checkbox"/> Picked-up by: _____ (ID is required for pick-up) <input type="checkbox"/> Paper				

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)*



(continued from front)

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