MetroHealth

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MAIDEN / OTHER NAME(S)	METROHEALTH MEDICAL RECORD #

CURRENT ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH (mm/dd/yy)	LAST 4 DIGITS SOCIAL SECURITY #	PHONE #	EMAIL ADDRESS
		( )	

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ❒ MEDICAL TREATMENT
- ❒ DISABILITY
- ❒ INSURANCE
- ❒ LEGAL
- ❒ PERSONAL
- ❒ OTHER: (please specify) _____

_____

3. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM (check as applicable):

❒ THE METROHEALTH SYSTEM ❒ METROHEALTH RECOVERY RESOURCES ❒ SPRY

❒ OTHER: (please describe) _____

INFORMATION TO BE DISCLOSED (check as many as applicable):

- ❒ Office Visits
- ❒ Emergency Department Reports
- ❒ Test Results (labs, pathology, radiology)
  - ❒ HIV/AIDS test results
- ❒ Cardiac Reports
- ❒ History & Physical
- ❒ Discharge Summary
- ❒ Operative Report
- ❒ Consultations
- ❒ Physical Medicine & Rehabilitation Notes
- ❒ Physical/Occupational Therapy Reports
- ❒ X-Ray Images
- ❒ ALL Behavioral health and substance use disorder records (except psychotherapy notes).
- ❒ Only those behavioral health and substance use disorder records listed below:
  - ❒Diagnostic ❒Drug test results ❒Billing/claims
  - ❒Mental health/addiction assessment
  - ❒Clinical notes ❒Medications

❒ Other: (please describe) _____

4. ACTIONS TO TAKE

RELEASE INFORMATION TO:

NAME OF RECIPIENT

ADDRESS	CITY/STATE	ZIP

PHONE NUMBER	FAX NUMBER
( )	( )

INFORMATION SHOULD BE DELIVERED ON (select one):

❒ **Release to MyChart** ❒ **Compact Disc (CD)** ❒ **Secure Electronic Delivery (If electronic, provide recipient's email)** ❒ **Fax**

❒ **Mail to the above address** ❒ **Picked-up by:**_____**(ID is required for pick-up)** ❒ **Paper**

I, the undersigned, authorize The MetroHealth System to release health information as indicated above. I understand and acknowledge that the requested health information could 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.

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MetroHealth

(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 and federal law as applicable. 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 substance use disorder treatment records that are protected by part 2,** MetroHealth provides this statement with each disclosure made with your consent: "42 CFR part 2 prohibits unauthorized disclosure of these records." This consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it.

Submit completed authorization to the following:

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

2. Email: ReleaseofInformation@metrohealth.org

3. Fax: (216) 778-2413

4. 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