



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:				
	<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				
3. INFORMATION NEEDED	INFORMATION TO BE DISCLOSED FROM (check as applicable):				
	<input type="checkbox"/> THE METROHEALTH SYSTEM <input type="checkbox"/> METROHEALTH RECOVERY RESOURCES <input type="checkbox"/> SPRY <input type="checkbox"/> OTHER: (please describe) _____				
4. ACTIONS TO TAKE	RELEASE INFORMATION TO:				
	NAME OF RECIPIENT				
4. ACTIONS TO TAKE	ADDRESS		CITY/STATE	ZIP	
	PHONE NUMBER ()		FAX NUMBER ()		
	INFORMATION SHOULD BE DELIVERED ON (select one):				
	<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 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.

(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 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