MetroHealth

REQUEST FOR ELECTRONIC HEALTH INFORMATION (EHI) EXPORT

This form is to request an export, provided as a computer-readable file, of all information within the patient's entire medical and billing record. This large file will take up a lot of space on your computer and can only be read by a software application. Each time an EHI export is requested, the system will capture the patient's entire medical and billing record up to the time of the request.

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. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM (check as applicable):

❒ THE METROHEALTH SYSTEM ❒ METROHEALTH RECOVERY RESOURCES ❒ SPRY

❒ OTHER: (please describe) _____

3. ACTIONS TO TAKE

RELEASE INFORMATION TO:

NAME OF RECIPIENT

ADDRESS	CITY/STATE	ZIP

PHONE NUMBER ( )	EMAIL ADDRESS

INFORMATION SHOULD BE DELIVERED ON (select one):

❒ **Compact Disc (CD) USA Mail to the above address** ❒ **Release to MyChart**

❒ **Secure Electronic Delivery (provide recipient's email address or electronic portal address)**

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.

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.

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MetroHealth

(continued from front)

If this request 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 form to the following:

1. Mail:
   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