Associates In Central Ohio OB/GYN

Patient Data Summary

Created On:

Location:

Provider:

BASIC INFORMATION

Name

Date Of Birth

Email Address

Who filled the form

ASSOCIATES IN CENTRAL OHIO OB/GYN (ACOOG) AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

Patient's Name:

Date of Birth:

Address:

Phone Number:

Email:

MR Location:

MR #:

Date(s) of Service:

Purpose of Release

- [ ] **Continuity of Care**
- [ ] **Leaving Practice/Change of Doctor (minimum document set)**
- [ ] **Self/Personal Reasons (minimum document set)**
- [ ] **Disability (minimum document set)**
- [ ] **Employment Related**
- [ ] **Research**
- [ ] **Legal Reasons**
- [ ] **Insurance**
- [ ] **Other**

Physician Practice/Organization Authorized to RELEASE Information:

Name:

Address:

City, State & Zip:

Fax #:

Phone #:

Person/Physician Practice/Organization Authorized to RECEIVE Information:

Name:

Address:

City, State & Zip:

Fax #:

Phone #:

Information to be released - for the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set, or Additional Document Set. Each type of record may or may not contain all the documents listed.

[ ] **Complete Record (*Maximum last 5 years)**
[ ] **Minimum Documents [the following will be sent for the last 2 years: progress notes/ radiology (if applicable)/ Labs (if applicable)/ other diagnostic test (if applicable)]**
[ ] **Additional Document (comprised of Minimum Documents plus the following selected items: medication lists/most recent pap smear/prenatal records/ pathology-operative report/ other-misc)**

Method of Release:

[ ] **Mail**
[ ] **Fax**
[ ] **other**

Consent Agreement

Expiration: This authorization for release of protected health information must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case please specify the date the consent will expire in the text box below. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the purpose and extent stated above.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that ACOOG has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the ACOOG Medical Records Department in the primary office at which you are seen.

Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). 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 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Fees: According to Ohio Revised Code, there is a per page fee for records. This fee will depend on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.
I hereby authorize the release of health information indicated above that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnosis.

Your signature

The above e-signature represents your agreement to the consent statement.

Signature of Patient (please type)

Today's Date

OPTIONAL: Consent expiration date (if requested to expire sooner than 60 days):

Signature of Patient's Legal Representative (if applicable)*

Relationship to Patient (if signed by Legal Representative)*

Today's Date (Only complete if signed by Legal Representative)*

*If signed by Patient's Legal Representative, please include a copy of the document authorizing you authority to act on behalf of the patient (e.g. health care power of attorney)