

ROI Authorization

MEDICAL RECORDS DEPARTMENT

TELEPHONE NUMBER: (513) 298-7750 FAX NUMBER: (513) 298-7765

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

West Chester, OH 45069

TO BE USED: 1) When patient or patient's legal representative requests use or disclosure of PHI; 2) for requests by or to an entity unless exceptions apply: 3) for use and disclosure of PHI for research (when patient has not signed a research informed consent that includes authorization or researcher has not received a waiver by the I.R.B. or privacy board); and 4) when no other exceptions apply.

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of the Health Alliance and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; 3) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: ____ Maiden: _____ Address: ____ City: ____ State: ____ Zip: ____ Date of Birth: _____ Social Security Number: _____ Phone: ____ COPIES SENT FROM/TO Agency/Hospital From: To: Name & Title of Person: West Chester Medical Center Street Address: 7700 University Drive 900 Memorial Drive



Lebanon OH 45036

City, State & Zip



ROI Authorization

Protected Health Information To Be Used or Disclosed

| Check box to indicate PHI that may be used or disclosed: | DATES Please provide specific dates of service. Requests for "any and all" |
|--|--|
| ☐ Inpatient ☐ Emergency Department ☐ Physical Therapy ☐ Same Day Surgery ☐ Outpatient | records may delay the processing of your request. |
| Pertinent summary documents from the above visits will be sent Face Sheet* History & Physical Consultation Reports* Discharge Summary* Operative Reports* Pathology Reports* Entire Record | t, unless specified reports are indicated below: Lab Reports* X-Ray Reports* Diagnostic Images Test Reports* Therapy Reports Emergency Treatment Other |
| Please specify the reason for your request: ☐ Medical Care ☐ Disability ☐ Leg | ason needed gal Reasons Insurance ner |
| I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be redisclosed by such person/entity and will likely no longer be protected by the federal privacy regulations. I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to Medical Record Department , Release of Information, West Chester Medical Center, 7700 University Drive, West Chester, Ohio 45069. | |
| | t my refusal to sign will not affect my ability to obtain treatment or payment arch purposes or unless the provision of treatment is related solely to the my employer. |
| EXPIRATION The authorization will expire in 60 days unless otherwise specif | ied as: (insert date or specific event) |
| protected health information concerning treatment, diagnosis, | alth information as described above. I authorize the hospital to release the or testing of drug or alcohol abuse, drug-related conditions, alcoholism, ency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV). |
| Patient/Legal Representative* *Reason Patient is unable to sign: | Date |
| *Describe scope of authority to act for patient:Provide guardianship, executor of estate, power of attorney paper. | |
| Witness Signature | Date |
| Retain original copy in Medical Records. Copy to natient or les | gal representative |

MRAUTE