Patient Authorization for Release of Information

THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Mailing Address: University of Toledo Medical Center
Release of Information Unit – Health Information Management
1015 Research Drive
Toledo, OH 43614
Phone: 419-383-4982 **Fax**: 419-383-3001

Patient Information	Recipient Information
Patient Name:_____	**Recipient Name:**_____
Birth Date:_____ **SS#**_____	**Address:**_____
Med Record Number (optional)**:** _____	_____
Address:_____	_____
_____	_____
_____	**Phone :**_____
Phone:_____	

1. **I hereby authorize UTMC, its Agents and its Employees to release Protected Health Information about Me/My child to the recipient which may include test results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information, if any.**

2. Information To Be Disclosed: (check all that apply)
   _____Outpatient Surgery Date of Service: _____
   _____Inpatient Admission Date of Service: _____
   _____Clinic or Office Visit Date of Service: _____
   _____Emergency Department Visit Date of Service: _____

   Specific Reports To Be Disclosed: (check all that apply)
   _____Discharge Summary _____Radiology/Ultrasound Reports
   _____History and Physical _____Pathology Reports
   _____Operative Reports _____Laboratory Reports
   _____Emergency Department Report _____Physician Progress Notes
   _____Psychotherapy Notes _____Complete Set of Medical Records
   _____Other:_____

3. Purpose of Disclosure: ___Continuation of Care ___Request of Patient Other (specify) _____

4. Information To Be:
   _____Copied and Mailed _____Viewed
   _____Copied and Picked Up _____Shared

5. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoke, this authorization is valid for 60 days.
6. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
7. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
8. UTMC may not condition my treatment or payment on my signing this document.
9. I have been informed that copies of my medical record(s) are subject to a copying fee. I have been informed that the UTMC utilizes an outside contracted copy service.
10. A Photocopy is as valid as the original.
11. Date of next appointment if known: _____

Signed: _____ _____ _____ _____
(Patient or Person Authorized to Consent) Date *(Witness Optional)* Date

_____
(Relationship to patient and authority to act in the patient's behalf)