AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

Printed Patient's Name_____ Phone _____

Patient's Address_____

Patient's Date of Birth_____ Patient's Social Security Number_____

Person/Organization Authorized to Release Information:

Name_____

Address_____

City, State & Zip Code_____

Person/Organization Authorized to Receive Information:

Name AMERICAN HEALTH NETWORK OF OHIO

Address family medicine on Cooper Road 660 Cooper Road Suite 600

City, State & Zip Code Westerville OH 43081

For the following protected health information:

_____ **2-year Record Summary** (Progress Notes, Radiology, Immunization, Labs, Meds, Consults)

_____ **Physician progress notes** Dates of Service _____

_____ **Lab/test results** Dates of Service _____

_____ **Radiology reports** Dates of Service _____

_____ **Urgent Care reports** Dates of Service _____

_____ **Entire medical record**

_____ **Other** (please specify) _____

For the purpose of:

_____ Continuity of Medical Care _____ Self

_____ Insurance Billing _____ Legal Reasons

_____ Other (please specify) _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, or healthcare operations. I may inspect or copy any information used/disclosed **under this authorization.**

This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from release of the information requested.

Patient's Signature_____ Date _____

Guardian/Legal Representative Signature_____

Witness_____ Date _____

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has been taken. **This authorization will expire automatically one year from the date on which it is signed.** Cancellation of this authorization prior to the limit must be made in writing and sent to the Mount Carmel HealthProviders specific physician office.

ALL SECTIONS MUST BE COMPLETED FOR RECORDS TO BE RELEASED.