Patient Name: ______________________ Date of Birth: ____/____/______
Address: ______________________ City: ______________ State: ________ Zip: __________
Phone: ______________________

I request that my protected health information (PHI) from Henry County Hospital be disclosed to:
Recipient Name: ______________________
Address: ______________________ City: ______________ State: ________ Zip: __________
Phone: ______________________
Fax (healthcare provider only): ______________________

I authorize the following PHI to be released from my medical record(s):

- ☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Radiology Report(s)
- ☐ Itemized Billing Records
- ☐ Abstract/Summary (Includes Discharge Summary, History and Physical, Operative Report(s), Consultations and Test Results)
- ☐ Physician Records of: ______________________
- ☐ Test Result(s) of: ______________________
- ☐ Other: ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Mental Health Records (Psychotherapy Notes) ☐ Yes ☐ No Dates: ______________________
HIV Testing and Results ☐ Yes ☐ No Dates: ______________________

Covering the period of healthcare from: Specific Date(s): ______________ to ______________

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

Disclosure Format (Paper if not marked): ☐ US Mail ☐ Fax ☐ Electronic copy on CD ☐ In-person pick up

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: ______________. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed or 60 days for mental health records.
- Treatment may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

______________________ ______________ ______________
Patient or Authorized Representative Signature Date Time

______________________ ______________________
Print Name Relationship to Patient (if applicable)

Copy to Patient: ______________ Witnessed by: ______________________
Date

1600 East Riverview Ave • Napoleon, Ohio 43545
(419) 592-4015

RELEASE OF INFORMATION

HIS-02 082621

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc.