Medical Record Number_____

Authorization for Use or Disclosure of Protected Health Information/Access to Protected Health Information

Patient Name: _____ DOB: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____

I, _____, hereby authorize Trinity Hospital Twin City or _____ to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information:

❑ Trinity Hospital Twin City
819 North 1st Street
Dennison, OH 44621
‘

Fax Number: _____

☐ _____
Street Address: _____
City:_____State:____Zip Code:_____

Fax Number: _____

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

___Discharge Summary
___Inpatient Records
___Emergency Room Records
___Complications and Procedures
___Abstracts
___Immunization (shot) record
___Outpatient Clinic Notes
___Other*:_____

___Reports of Tests & X-rays
___Final Diagnosis
___Outpatient Records
___Consultation Reports
___History & Physical Records
___Physical Therapy Notes

*If authorization is for *marketing*, indicate if Trinity Hospital Twin City will receive compensation in exchange for the use and/or disclosure of the PHI. ___YES or ___NO

Dates of treatment to be released: _____

I request the form of the information to be ___Paper ___Electronic

Specify preference for Electronic release: _____

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Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record.

Prohibition on Conditioning of Authorization: Trinity Hospital Twin City will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire in 90 days or once purpose stated above is served.

Revocation: I understand that I may revoke this authorization at any time by notifying Trinity Hospital Twin City in writing by sending a letter to **Trinity Hospital Twin City, Medical Records, 819 North 1st Street, Dennison, OH 44621** or by completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Trinity Health System took before it received my revocation letter. For example, Trinity Hospital Twin City cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Trinity Hospital Twin City's Notice of Privacy Practices.

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_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE**

_____

Printed name of individual's personal representative, if applicable.

_____

Rationale for serving as personal representative to the individual (e.g. parent, legal guardian).

FOR INTERNAL PURPOSES ONLY

When Trinity Hospital Twin City is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___YES ___NO

Access approved? ___YES ___NO