AUTHORIZATION FOR USE & 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 Birthdate: _____

Social Security Number: _____

Person/Organization Authorized to Release the information:	Person/Organization Authorized to Receive Information:
_____	_____
_____	_____
_____	_____

For the following dates of treatment (include specific description of information requested):

_____

_____

For the purpose of: *(Optional)*

_____ Further Medical Care
_____ Insurance Billing
_____ Legal Reasons
_____ Self
_____ 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 the 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 except to the extent that action based on this authorization has been taken. ***This authorization will expire automatically 60 days from the date on which it is signed.*** Cancellation of this authorization prior to the 60-day limit must be made in writing and sent to the Health Information Management Department at the appropriate site listed below:

Mount Carmel West
Attn: HIM Dept.
793 W. State St.
Columbus, OH 43222

Mount Carmel East
Attn: HIM Dept.
6001 E. Broad St.
Columbus, OH 43213

Mount Carmel St. Ann's
Attn: HIM Dept.
500 S. Cleveland Ave
Westerville, OH 43081

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DT0195

Mount Carmel, Columbus, Ohio

Authorization for Use of Disclosure of Protected Health Information

31008-4-03 (Obetz) Patient Chart

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