AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
OHIO COUNTY HOSPITAL CORPORATION

Patient name: _____ **MR #: _____**

Birthdate: _____ **ID Number: _____**

Person/organization authorized to provide the information: **Person/organization authorized to receive the information**

_____ _____
_____ _____
_____ _____
_____ _____

Specific description of information to be disclosed (Specify if disclosure includes alcohol, drug, psychiatric or HIV/AIDS records) (Include specific dates):

_____
_____
_____
_____

1. Ohio County Hospital Corporation must complete the following:

   a. List each purpose of the use and/or disclosure:_____
   _____
   (If individual requests authorization and does not provide a purpose, the hospital/corporation may answer: "At the request of the individual")

   b. Will Ohio County Hospital Corporation receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No _____

2. **The patient or the patient's representative must read and initial the following statements**:

   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form, unless:
      i) the treatment is research related and the use and/or disclosure is for that research; or
      ii) the health care to be provided is solely for the purpose of creating health information for disclosure to a third party and the Ohio County Hospital Corporation asks for an authorization to disclose the information to the third party (e.g., a work-related physical).
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
   c. I understand that this authorization will expire on __ __/__ __/__ __ __ __(DD/MM/YR); or 60 days.
      If for research, select one of the following expiration times: _____end of research study _____ none
   d. I understand that I may revoke this authorization at any time by notifying Ohio County Hospital Corporation in writing, but if I do, it will not have any affect on any actions taken by Ohio County Hospital Corporation prior to receiving the revocation. If the authorization was obtained as a condition of obtaining insurance coverage, I understand that my revocation will not affect the insurer's legal rights to contest a claim under the policy or the policy itself.

Initials:_____

I hereby authorize the use and/or disclosure of my protected health information as stated. I understand that this authorization is voluntary. I understand that if the person or organization authorized to receive the information is not a health plan, health care clearinghouse, or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

3. Identity of Requestor verified via: □ Photo ID □ Matching Signature □ Other Specify_____

_____ _____ _____
Signature of patient or patient's representative **Date** **Witness**
(Form MUST be completed before signing.)

Printed name of patient's representative:_____
Relationship to the patient:_____
Description of authority to act for patient:_____
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