PATIENT INFORMATION/LABEL

Patient Name_____

DOB_____ MR□□□□□□□□

CSN□□□□□□□□□□Date_____

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION

MRN

LAST NAME	FIRST	MIDDLE	MAIDEN
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ❑ CONTINUITY OF CARE/MEDICAL TREATMENT ***(MINIMUM DOCUMENT SET** will be submitted unless otherwise indicated below)*
- ❑ PERSONAL USE
- ❑ LEGAL REASONS
- ❑ INSURANCE OR PAYMENT **(*Please circle applicable insurance/payment purpose from the list below)***:

  [BUREAU OF WORKERS COMP] [DEPARTMENT OF JOB AND FAMILY SERVICES] [INDUSTRIAL COMMISSION]

  [SOCIAL SECURITY DISABILITY OR SUPPLEMENTAL SECURITY INCOME (SSI)] [OTHER INSURANCE/PAYMENT]
- ❑ OTHER REASON **(*Please specify*)**: _____

3. SCOPE (WHEN AND WHERE)

SPECIFY GENESIS ENTITY INFORMATION TO BE DISCLOSED FROM:

- ❑ GENESIS HEALTHCARE SYSTEM D/B/A GENESIS HOSPITAL (*For Genesis Hospital inpatient and outpatient and outpatient clinic records*)
- ❑ GENESIS MEDICAL GROUP (GMG) (*For GMG physician office records)*
- ❑ OTHER **(*Specify*)**:_____

SPECIFY: TYPE OF RECORD REQUESTED:	**DATES OF SERVICE(S)**	**ADDITION LOCATION DETAILS (*if needed*):**
❑ INPATIENT	_____	_____
❑ OUTPATIENT (INCLUDES DEPTS/CLINICS)	_____	_____
❑ EMERGENCY DEPARTMENT	_____	_____
❑ PHYSICIAN OFFICE	_____	_____
❑ OTHER: _____	_____	_____

If you wish to EXCLUDE any records or dates of service, PLEASE SPECIFY IN THE SPACE BELOW:

_____

_____

_____

❑ **NOTE:** If you do not indicate above your request for specific exclusion(s), information will be disclosed within the requested records, which may include any HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS if existing in your record to the extent permissible by state and federal law. **A separate authorization is required for the release of psychotherapy notes.**

4. RECORDS/DOCUMENTS (CONTENT)

CONTENT/DESCRIPTION OF INFORMATION TO BE RELEASED- For the record(s) selected above, specify content in the areas below. Each type of record may or may not contain all the documents listed.

❑ **COMPLETE RECORD***

* Please note, requests for a complete record may take 30-60 days to process, may include duplicate or excessive information, and may result in higher fees to you based on the record size and applicable fee schedule

MINIMUM DOCUMENT SET (check one or more of the documents, or all):

- ❑ FACESHEET
- ❑ DISCHARGE SUMMARY
- ❑ HISTORY AND PHYSICAL
- ❑ CONSULTS
- ❑ PROGRESS NOTES
- ❑ OPERATIVE REPORTS
- ❑ EMERGENCY RECORDS
- ❑ PATHOLOGY
- ❑ TEST RESULTS (lab, radiology, EKGs, EEGs, Echo)
- ❑ OTHER_____
- ❑ ASSAULT RECORDS

❑ **ALL OF THE ABOVE**

ADDITIONAL DOCUMENT SET (Select each of the following additional documents requested):

- ❑ PHYSICIAN ORDERS
- ❑ NURSING NOTES
- ❑ GRAPHICS
- ❑ PHYSICAL THERAPY/SOCIAL SERVICE NOTES
- ❑ NUTRITION SERVICES NOTES
- ❑ CONSENTS
- ❑ MEDICATION LISTS
- ❑ ANESTHESIA RECORDS/OTHER SURGERY DOCUMENTS
- ❑ PHOTOGRAPHS, VIDEOTAPES, DIGITAL OR OTHER IMAGES
- ❑ OTHER_____

This authorization cannot be used to release Part 2 (substance use disorder) patient records. In order to obtain Part 2 records from the Genesis HealthCare System Health Information Management Department, a "Consent for Release of Part 2 Program (Substance Use Disorder Provider) Information" form will need to be completed

804198

PATIENT INFORMATION/LABEL

Patient Name_____

DOB_____ MR□□□□□□□□

CSN□□□□□□□□□□Date_____

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

5. SEND TO INFORMATION

MAIL TO ORGANIZATION/AGENCY		ATTN:	
ADDRESS	CITY	STATE	ZIP
PHONE #			
❑ FAX TO: FAX #		❑ VERBAL EXCHANGE	

I prefer to receive my medical record in the following format:

- ❑ IN-PERSON REVIEW ONLY (DATE & TIME): _____
- ❑ PAPER
- ❑ CD (for patients only)
- ❑ SECURE LINK
- ❑ RELEASE TO MYCHART (for patients only)

6. ACKNOWLEDGEMENTS

Authorization:

- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and may no longer be protected by the federal privacy regulations.
- I understand that I am not required to sign this authorization form and that Genesis HealthCare System will not condition the provision of treatment or payment to me on the signing of this authorization, except that Genesis HealthCare System may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my protected health information for such research. Genesis HealthCare System may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.
- I understand that by signing this authorization for the purpose of research, it gives the researcher(s) the permission to use or disclose my personal health information for such research.
- I understand that my records/protected health information cannot be released pursuant to an authorization unless I sign this form.

Revocation: As described in the Notice of Privacy Practices of Genesis HealthCare System, I understand that I may revoke the authorization in writing at any time by sending a written revocation to Genesis HealthCare System / Health Information Management Department / 2951 Maple Avenue / Zanesville, Ohio 43701, and that no further release shall occur except to the extent that such action has been taken by Genesis HealthCare System in reliance on this authorization prior to notice of revocation.

7. EXPIRATION

This authorization for release of protected health information for the date of service indicated is effective until ____/____/_____ or, if no date is specified or if such specified date exceeds one year from the date signed below, for a period of one year from the date signed below.

I hereby authorize Genesis HealthCare System to disclose to the party (parties) named in this document, information from my medical record as specified herein.

X Signature of Patient _____ **Date**_____ **Time**_____

Signature of Authorized Representative of Patient _____**Date**_____ **Time**_____

Printed Name of Individual Authorized by Patient_____ **Relationship to Patient**_____

8. FEES

You may be charged a fee for copies of medical records in accordance with Ohio Revised Code 3701.741. If you have questions about an invoice you have received or the records release process, please contact Genesis HealthCare System at 1-740-454-5905 (press #3) or toll-free at 1-800-322-4762, ext. 5905 (press #3).

❑ **ID Check (Employees Must Check ID)**

Request taken by: _____

Released by: _____

This authorization cannot be used to release Part 2 (substance use disorder) patient records. In order to obtain Part 2 records from the Genesis HealthCare System Health Information Management Department, a "Consent for Release of Part 2 Program (Substance Use Disorder Provider) Information" form will need to be completed