UC Health

ROICOR

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

(RELEASE OF INFORMATION)

***This request is to release medical records for**:

Last Name _____ First Name _____ Middle_____ Date of Birth _____

Maiden Name_____ Last 4 of Social Security Number _____ Telephone Number_____

Address (Street, City, State, ZIP Code) _____

***Medical records release from: (Check a box for location)**

Location	☐ Daniel Drake Center for Post-Acute Care (DDC)	☐ University of Cincinnati Medical Center (UCMC)	☐ University of Cincinnati Physician Office *	☐ West Chester Hospital (WCH)
Mailing Address	Medical Records Services University of Cincinnati Medical Center 234 Goodman St.; ML0738 Cincinnati, OH 45219		UCP/MRO – Suite 2830 Victory Parkway Cincinnati, Ohio 45206	Medical Records Services West Chester Hospital 7777 University Drive, Suite A West Chester, OH 45069
Phone Number	(513) 584-0444		(513) 245-3711	(513) 298-7750
Fax Number	(513) 584-0739		(844) 239-8077	(513) 298-7765
Email Address	Drake-medical-records@uchealth.com UCMC-medical-records@uchealth.com			WCH-medical-records@uchealth.com

***If you selected UC Physician Office, please specify provider name, location or specialty: _____**

***Medical records release to:**

Name of Person or Organization: _____

Address (Street, City, State, Zip Code)_____

Recipient Phone #: _____ Recipient Fax #: _____

E-mail address: _____ Send to MyChart _____

***Treatment Dates: From _____ To: _____**

***Purpose of Request: ☐ Self/Personal ☐ Continuity of Care ☐ Legal ☐ Disability ☐ Insurance**

The following information to be disclosed (please check):	☐ Abstract ☐ Discharge Summary ☐ History and Physical examination ☐ Consultations, Including psychiatric evaluations ☐ Operative report or procedure reports ☐ Emergency Department Record ☐ Laboratory reports, including drug screens	☐ Radiology or x-ray reports ☐ Interdisciplinary records (progress notes) ☐ Medication lists and documentation ☐ Nursing notes ☐ Physician orders ☐ Other _____
Sensitive Information	I understand that the information in my records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.	
Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing via mailing or faxing to one of the locations listed above. I understand that revocation will not apply to information that has already been released based on this authorization.	
Expiration	Unless otherwise revoked, this authorization will expire on the following date or when the following event or condition occurs: _____ **If I do not specify an expiration date, event, or condition, this authorization will expire in 1 year.**	
Re-disclosure	I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.	
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. Research participation requires a separate authorization by the patient. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact the Health Information Management (HIM) Department by calling the number listed above.	

***Date: _____ Time: _____ *Print Name: _____**

Signature of Patient or Legal Representative *: _____

If Signed by Legal Representative, relationship to patient _____

Legal representative must provide a copy of guardianship, Executor of Estate, or Power of Attorney (POA) documents

Copy to individual

UC Health

Quick Tips for Requesting Your Medical Record

- For "Continuity of care" the receiving caregiver typically only wants to receive an "Abstract" of key information from the medical record. The same "Abstract" sent to caregivers also almost always meets the need for individual use.
- A Medical Record "Abstract" contains the following:
  - ✓ Discharge Summary – this document is a summary of the care, treatment, and services.
  - ✓ Emergency Department Record
  - ✓ History and Physical – this form details the history of present illness and any relevant past history
  - ✓ Operative Reports – this report details the surgeon's findings, technical procedures used, specimens removed and postoperative diagnosis
  - ✓ Consultation(s) Reports(s) – this report documents the findings of a physician requested to examine a patient
  - ✓ Radiology, X-ray & Lab reports

  MyChart request will be a limited set of records. They will not be the entire record.
- **There is a charge for medical records copies.** Requestors will be sent a prepayment invoice from our copying service MRO. Upon determination of total cost and once payment is received, the charts will be sent.

  ****Please note:** The state of Kentucky is the only place that offers 1 FREE copy of your chart, NOT Ohio**
- The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers 30 days to process records. UC Health puts forth every effort to provide records more timely, however occasionally the full 30 days are required to fulfill your request.