☐ The Toledo Hospital
☐ Toledo Children's Hospital
☐ Flower Hospital

Pt. Name _____
MRN # _____
Acct # _____
Date(s) of Service _____

Nursing

Authorization to Disclose Health Information

Return to our Fax (419) 479-6919

Patient Name: _____

Social Security # _____ Date of Birth: _____

Organization authorized to **DISCLOSE** information:
The Toledo Hospital / Toledo Children's Hospital / Flower Hospital

⇨ Person/Physician/organization authorized to **RECEIVE** the information (including address)
_____

⇨ **Date(s) of service/care for information requested** _____

⇨ Information to be disclosed (include dates where appropriate):

- ☐ Entire Record _____
- ☐ Emergency Records _____
- ☐ Discharge Summary _____
- ☐ History & Physical _____
- ☐ Operative Report _____
- ☐ Consultations _____
- ☐ Pathology Report _____
- ☐ Laboratory Reports _____
- ☐ Progress Notes _____
- ☐ Physician Orders _____
- ☐ X-rays/EKG's _____
- ☐ Therapy Records _____
- ☐ Alcohol/Drug _____
- ☐ Other (specify) _____

⇨ Purpose of disclosure:

- ☐ Continuation of medical care
- ☐ Substantiation of payment claims/Insurance
- ☐ Social Security/Disability
- ☐ Attorney
- ☐ Personal use
- ☐ Other (specify) _____

⇨ Information should be delivered via (select one): Your Phone #: _____

- ☐ I will inspect and review the record on-site
- ☐ Mail to address above
- ☐ Pick-up (provide name of individual picking up information): _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol & drug abuse.
2. 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 could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the evocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization will expire in 1 year; for Michigan entities this authorization will expire in 60 days. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.

X _____ X _____
Signature of Patient or Legally Authorized Representative — Date

Relationship to Patient: _____ Witness: _____ Date: _____

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)

- ☐ Parent
- ☐ Legally Authorized Representative
- ☐ Other (specify and attach proof) _____
- ☐ Durable Power of Attorney for Health Care
- ☐ Personal Representative of the Estate