

REQUEST FOR MEDICAL RECORDS

Acuity Specialty Hospital of Ohio Valley at Belmont

Third Party Request for Release of Information

I, _____ **GIVE PERMISSION TO RELEASE THE PROTECTED HEALTH INFORMATION OF (PLEASE PRINT):**

First Name:	MI:	Last Name:
Date of Birth:	Phone:	Last 4 digits SSN:
Address:	City:	State & Zip:

WHICH RECORDS WOULD YOU LIKE TO RECEIVE? (ENTER THE ADMISSION AND DISCHARGE DATE, THEN SELECT THE APPROPRIATE BOX(ES)):

Admission Date:	Discharge Date:
<input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultations <input type="checkbox"/> Progress Notes <input type="checkbox"/> Operative Reports	<input type="checkbox"/> Diagnostic Test Results <input type="checkbox"/> Laboratory Results <input type="checkbox"/> X-ray/CT/MRI Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> EKG's / ECG's
<input type="checkbox"/> Drug/Alcohol Records <input type="checkbox"/> HIV Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Medications <input type="checkbox"/> Other (Please Specify): _____	<input type="checkbox"/> Face Sheet <input type="checkbox"/> Abstract <input type="checkbox"/> Itemized Bill

PURPOSE OF RELEASE (SELECT ONE): Request of patient/personal Medical Care Insurance Disability Worker's Compensation
 Legal purpose including discussions & proceedings Other: _____

HOW WOULD YOU LIKE TO RECEIVE THE REQUESTED MEDICAL RECORDS?

Select one: <input type="checkbox"/> CD <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Paper Copies → <input type="checkbox"/> Mail <input type="checkbox"/> On-site Pick Up
NOTE: E-mail and CD will be encrypted or password protected unless otherwise requested here → <input type="checkbox"/> No encryption or password required

PLEASE INDICATE WHERE YOU WOULD LIKE THE RECORDS TO BE SENT (PLEASE COMPLETE APPLICABLE SECTION(S) BELOW):

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail:

I UNDERSTAND THAT:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.
- THIS AUTHORIZATION WILL EXPIRE IN 6 (SIX) MONTHS OR (SPECIFY DATE OR EVENT): _____

Relationship and authority to act*: <input type="checkbox"/> Healthcare Agent/POA <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Guardian <input type="checkbox"/> Next of Kin <input type="checkbox"/> Parent <input type="checkbox"/> Executor/Administrator/Attorney in Fact <input type="checkbox"/> Other: _____
Printed Name _____ Signature _____ Date _____ <i>* If Acuity Healthcare does not have documentation of this authority to act, you may be asked to provide copies of signed documentation of such authority.</i>

PLEASE RETURN COMPLETED AND SIGNED FORM TO (REQUESTS MAY BE RECEIVED VIA MAIL, FAX OR EMAIL ATTACHMENT):

Health Information Management Director - ROI Acuity Specialty Hospital of Ohio Valley at Belmont 4697 Harrison Street – 2 nd Floor Bellaire, OH 43906	Fax: 740-671-2095 Phone: 740-671-2089
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- There may be a fee associated with producing requested records. Please see the fee schedule for this Acuity Healthcare facility.

For Office Use Only

Date of release: _____ via mail fax CD other _____ ID verified DL/Other ID _____
Employee Name & Title: _____ Date: _____ Time: _____

***** ATTENTION *****

This message may contain confidential and/or privileged information. If you are not the addressee or authorized to receive this for the addressee, you must not use, copy, disclose, or take any action based on this message or any information herein. If you have received this message in error, please advise the sender by fax immediately and destroy this form. Thank you for your cooperation.