INSTRUCTIONS ON HOW TO FILL OUT THE “AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION”

Printed Patient’s Name: Please print the patient’s first name, middle initial, and last name.
Phone: Please enter the patient’s telephone number including area code.
Address: Please enter the patient's complete mailing address.
Patient’s Birthdate: Please enter the patient’s month, day, and year of birth.
Social Security Number: Please enter the last 4 digits of the patient’s social security number, if available.

Please select the Mount Carmel facility from which you are requesting records: Please check the facility or facilities from which medical records are being requested. If the facility is not listed, please write in the name of the medical facility under Other.
List Date(s) of Treatment: Please enter the date(s) that the patient was seen at the facility or facilities. An approximate date or date range can be used.
Please select records: Please check the type of document(s) that are needed from the patient's chart. If applicable, please list under Other any additional document(s) that are needed.

Recipient of the Medical Records: Please provide the Name and complete mailing Address of who is to receive medical records.

For the Purpose of: Please check or enter the reason that best describes why the records are being requested.

Sign Here: The patient or the patient's representative must sign. Supporting documentation for the Personal Representative may be required. Please see the following details regarding patient representatives:

1. If patient is a minor - the parent of record is responsible for signing. There may be exceptions so, please ask an HIM associate for more information.
2. If patient has a guardian - a copy of guardianship document is required. The guardian is responsible for signing the request.
3. If patient has a Power of Attorney – a copy of the Power of Attorney (P.O.A) document is required and must include the release of healthcare information in the scope of responsibilities. The P.O.A is responsible for signing the request if the patient is unable to sign.
4. If the patient is deceased – a copy of executor or administrator of estate document is required. The executor or administrator is responsible for signing the request.
   a. A copy of the Death Certificate is required if the patient expired outside of the Mount Carmel Health system.

Date: The patient or the patient’s representative is to enter the date the request was signed.
Print name of patient's Personal Representative, if applicable: If the request was signed by the patient's Personal Representative, please print the Personal Representative's name.
Describe Relationship to patient: Please enter how the Personal Representative is related to the patient (e.g. HCPOA, guardian, parent)

The completed form can be submitted in person or mailed to Mount Carmel St. Ann's or emailed to himpatientrequest@mchs.com.

Revised 11/19/18
PATIENT INFORMATION

Printed Patient’s Name ___________________________________________ Phone (_____)________-__________
Address _________________________________________________________________________________________

Patient’s Birthdate ______________________________ Social Security Number (last 4 digits) _____________________

DESCRIPTION OF MEDICAL RECORDS
This authorization includes information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, AIDS/HIV, psychiatric/psychological/mental health conditions or treatment which are contained in the records I indicate below.

Please select the Mount Carmel facility from which you are requesting records:
☐ East   ☐ West   ☐ St. Ann’s   ☐ New Albany   ☐ Grove City   ☐ Lewis Center   ☐ Diley Ridge Medical Center   ☐ Other ___________________

List Date(s) of Treatment __________________________________________________________________________

Please select records:
☐ Emergency Department Records   ☐ Discharge Summary   ☐ History and Physical
☐ Consultations   ☐ Operative Report   ☐ Pathology
☐ Progress Notes   ☐ Test Results   ☐ Complete Medical Record
☐ Other (list) ____________________________________________________________

RECIPIENT OF THE MEDICAL RECORDS:
Name ___________________________________________________________________________________________
Address _________________________________________________________________________________________

FOR THE PURPOSE OF:
☐ Continuity of Care   ☐ Legal Reasons   ☐ Other (please specify) ___________________
☐ Payment/Financial Purposes   ☐ Patient Request

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by the recipient and no longer protected by these regulations.

If I refuse to sign this Authorization Mount Carmel/Diley Ridge (as applicable) will not withhold treatment from me and will not release the information to the recipient specified above.

I understand that I may revoke this authorization at any time by notifying Mount Carmel in writing by sending a letter to the attention of Health Information Management at the address below. I understand that if I revoke this Authorization, it will not affect any actions that the Mount Carmel/Diley Ridge took before receipt of my revocation letter.

This authorization will expire automatically one year from the date on which it is signed.

SIGN HERE ___________________________________________ Date ___________________________________________

Printed name of patient’s Personal Representative, if applicable __________________________________________

Describe Relationship to patient (e.g. minor’s parent, guardian) ________________________________________

Deliver in person or mail authorization form to:
Mount Carmel St. Ann’s, 495 Cooper Road, Suite 200, Westerville, OH 43081  (380) 898-4075
Or deliver via email to: himpatientrequest@mchs.com

NAME

DOB

MR #

FIN #