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: ☐ Mount Carmel East
☐ Mount Carmel St. Ann's ☐ Mount Carmel Grove City ☐ Mount Carmel New Albany ☐ Mount Carmel Dublin
☐ Hillard ☐ Lewis Center ☐ Diley Ridge Medical Center ☐ Reynoldsburg ☐ Franklinton ☐ 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 (Fee applied)
☐ Radiology Imaging	☐ 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 _____

Signature of Patient or Personal Representative Date

Printed name of patient's Personal Representative, if applicable _____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

DELIVER THE COMPLETED SIGNED AND DATED FROM VIA:

MRO Secure Fax Line: 833-381-1104 **Email:** ROI@mchs.com

Mailed: Mount Carmel St. Ann's, 500 South Cleveland Avenue, West Wing 208, Westerville, Ohio 43081

Mount Carmel, Columbus, Ohio

Authorization for Use & Disclosure of Protected Health Information

31008-1-25

NAME

DOB

MR #

CSN #