FISHER | TITUS

Medical Record#_____

AUTHORIZATION TO DISCLOSE PHI (Protected Health Information)

1. PATIENT INFORMATION:

Patient Name: _____ DOB:_____ SS#: _____

Address: _____ City _____ State_____ Zip _____

Phone: _____ Email:_____

2. PERSON OR COMPANY WHO WILL RECEIVE INFORMATION:

☐ Self (same info as above)

☐ Person or Entity: _____ Phone: _____

Address: _____ Fax: _____

Email: _____

3. TREATMENT LOCATION:

☐ Fisher-Titus Medical Center (Hospital) **Phone: 419-660-2702 Fax: 419-660-2709**

Fisher-Titus Family Medicine: Phone: 419-660-2734 Option 2 Fax: 419-660-2695

☐ Family Medicine Wakeman ☐ Family Medicine Milan ☐ Convenient Care ☐ Family Medicine New London
☐ Norwalk Primary Care ☐Family Medicine Willard

Fisher-Titus Specialty Offices: **Phone: 419-660-2734 Option 2 Fax: 419-660-2695**

☐ Gen. Surgery ☐Digestive Health ☐ Endocrinology ☐ Executive Urology ☐Pediatrics ☐Women's Health

4. PURPOSE OF REQUEST:

☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Other (specify): _____

5. INFORMATION TO BE RELEASED (check all that apply and include dates of service)

Records or Information:

☐ Discharge Summary (date)_____
☐ History & Physical (date)_____
☐ Consultation Report (list physician name & date) _____
☐ Operative Report (date) _____
☐ Laboratory Reports (list date/type of test) _____
_____
☐ Pathology Reports (date)_____
☐ Radiology Reports (list date(s) or type(s) of reports)_____
_____
☐ Radiology Images (list date(s) or type(s) of images)_____
_____
☐ Therapy (OT, PT, SPH, AUD) (list date(s) or type(s) of therapy records)_____
☐ Immunization Record (date) _____
☐ Emergency Dept. Record (date)_____
☐ Clinic Visit-Specify Provider/Clinic (list date(s)/type(s) of record(s))_____
☐ Other (please specify) _____
☐ Entire Record From: (date or date range)_____
☐ Billing Records (date(s) of the service) _____
☐ Any future records through one year of signature _____

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6. FORMAT AND DELIVERY OF INFORMATION:
Format (Select only one) ☐ CD (Hospital only) ☐ Encrypted Email ☐ Flash drive (Physician Practices Only) ☐ Paper

Delivery Method (select one only): ☐ Fax ☐ Mail ☐ In-Person Pick Up

7. REVIEW AND APPROVAL:
I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS, or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Alcohol/Drug Abuse Treatment/Referral
☐ Mental Health (other than Psychotherapy)
☐ Sexually Transmitted Disease
☐ HIV/AIDS Related Treatment

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Fisher-Titus Health will continue to provide treatment and seek payment for services provided. Fisher-Titus Health may charge a fee for providing the information specified above.

8. <u>This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here:</u> _____

_____ _____ _____
Signature Printed Name Date

_____ _____
Witness signature Date

REPRESENTATIVE (complete if signed by personal or authorized representatives)

_____ _____
Representative Full Name Date

_____
Representative Full Name (please Print)

_____
Relationship to Patient