Madison HEALTH
210 N. Main St.
London, OH 43140

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Medical Records - 740-845-7102 Fax - 740-845-7101

Name:_____ DOB: ___/___/___

Address:_____ City, State, Zip:_____

SSN:_____ Medical Record Number:_____ Phone Number:_____

Patient ID verification: ☐ Driver's license ☐ Other_____

I do hereby authorize Madison Health to disclose information to: _____

I do hereby authorize_____ to disclose information to Madison Health.

☐ Please mail ☐ Information will be picked up ☐ Please fax

Recipient's Address:_____ Phone:_____ Fax:_____

Information to be disclosed includes: (Select all that apply)

☐ Discharge Summary ☐ History/Physical ☐ Billing
☐ Radiology Film(s) ☐ Operative Report ☐ SP/PT/OT
☐ Cardio/Pulmonary ☐ Social Services ☐ **All Records**
☐ ER Record ☐ Labs/Radiology ☐ Consults (specify physician)_____

☐ Other (please specify)_____

_____

for dates including _____ to _____

The record includes information on the following: (select all that apply)

☐ Substance abuse ☐ HIV/AIDS ☐ STD ☐ Mental disorder

I understand that the purpose of this disclosure is for:

☐ Use in future medical care/Continuity of Care ☐ Legal
☐ Use of personal nature ☐ Insurance ☐ Other (please describe)_____

I also 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 Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire in 120 days unless otherwise specified. Date of expiration:_____

1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under number 2 on this form.
2. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain information, and I refuse to sign this authorization, Madison Health reserves the right to deny that healthcare.
3. I understand that I may inspect or copy the information used or disclosed.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Madison Health.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ _____
Signature of Patient or Legal Representative of Patient — Date of Signature

_____
Printed Name of Patient Representative

_____ _____
Signature of Witness — Date of Signature

Requesting your records- Recent changes in Ohio legislation now require hospitals to charge patients who request copies of their patient information. Madison Health has implemented a revised fee structure in accordance with Ohio Revised Code 3701.742.

Fee schedule for Patients and their Representatives.

* 1 to 10 pages	$2.73/page
*11 to 50 pages	$.57/page
*51 plus pages	$.23/page

Fee schedule for all other requesters:

*Base Fee	$16.78
* 1 to 10 pages	$1.11/page
*11 to 50 pages	$.57/page
*51 plus pages	$.23/page

Please Note: $1.86 /page for data retrieved from sources other than hard copy records.

Individual Rights for Access to Personal Health Information

As provided by the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to:

1. Psychotherapy
2. Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
3. Protected health information that is:
   a) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to you would be prohibited by law; or
   b) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42CFR 493.3(a)(2).

Madison Health will act on this respect within 30 days of the date requested or, within 60 days if the requested information is not maintained or accessible to Madison Health on-site. Such action will either inform you of the acceptance of the request and provide you with the requested information in a readable hard copy format; or provide a written denial explaining the reasons for the denial and whether you are entitled to the denial reviewed.