

Authorization to Release  
Copies of a Medical Record

Please complete this form in its  
entirety so we can help you receive the  
information you are requesting.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

e-mail Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Send to  Send from company/Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose of release/disclosure to other person/organization:**

Continuity of Care  Request of Patient  Other (specify): \_\_\_\_\_

Outpatient Surgery, Date of Service: \_\_\_\_\_  Clinic or Office Visit, Date of Service \_\_\_\_\_

Inpatient Admission, Date of Service: \_\_\_\_\_  Emergency Department Visit, Date of Service \_\_\_\_\_

**Information to be released: (check all that apply)**

Discharge Summary  Emergency Department Reports  Radiology/Ultrasound Reports  Billing

History & Physical  Physician Progress Notes  Laboratory Reports  Complete Set of Medical Records

Operative Reports  Psychiatric Health Record  Other: \_\_\_\_\_

Alcohol & Drug Detox/Treatment, specifically: \_\_\_\_\_

**How much/what kind of information; explicit description of substance use disorder information that may be disclosed**

**Information to be:**  Electronic Delivery (see instructions on back)  Pick Up  CD  Paper copy  Mailed

1. I hereby authorize The University of Toledo Medical Center (UTMC), its agents and its employees to release Protected Health Information about me/my child to the recipient which may include tests results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information if any.
2. I am the patient, or the legally authorized representative of the patient, listed above. I request The University of Toledo Medical Center to release my protected health information (or the patients information listed above to:
3. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taking in reliance on this authorization. Unless otherwise revoked this authorization is valid for 60 days or date/condition/event: \_\_\_\_\_
4. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
6. UTMC may not condition my treatment or payment on my signing this document.
7. I have been informed that UTMC utilizes an outside contracted copy service. I have been informed that copies of my medical record(s) are subject to a copying fee, Please see second page regarding our fee schedule.
8. A photocopy is as valid as the original

\_\_\_\_\_  
Patient or Person Authorized to Consent Date Time

\_\_\_\_\_  
Patient Signature Relationship to Patient

**Notice to Recipient:** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Office Use Only** ID Verified:  Yes  No Date Received: \_\_\_\_\_ Date Processed: \_\_\_\_\_

Information:  Mailed  Picked Up  Faxed Processed By:  HIM Staff  Other: \_\_\_\_\_



**REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON**

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include. Letters of Representation, Guardianship papers, Affidavits of Heir at Law, etc. Please contact the Release of Information Unit at (419) 383-4982 to determine the documentation that will be required to process your request.

**SUBMITTING REQUESTS & RECEIVING RECORD COPIES**

Patient authorizations need to be submitted for release of protected patient health information. Requests for medical records generally take 7 to 10 working days to process. A completed authorization needs to be signed and dated by the patient or legal guardian.

**For request for continuing medical care, the following will be sent:**

- Office Progress Notes
  - Discharge Summary
  - Emergency Report
  - History and Physical
  - Operative Report
  - Results of any diagnostic reports (i.e.: x-ray, MRI, labs, EKG, etc.)
- There is no charge for records released to your physician for continuing medical care

**ELECTRONIC DELIVERY OF YOUR MEDICAL RECORDS**

Fax your signed copy to 419-383-3001. Once enabled, you will receive two (2) e-mails. The first e-mail contains the invoice number, and the second e-mail contains a Personal Identification Number (PIN). These e-mails will provide instructions on how to access records on the eDelivery website.

**Request for Personal Use:**

**Charges apply:**

- No charges for records released to your physician for continuing medical care.
- \$0.05 per page for supplies (paper and toner) plus actual postage.
- \$0.90 flat labor fee to create EMR (electronic medical record)
- \$6.50 fee plus tax if record is delivered via e-delivery.
- \$5.00 fee for personal copy of radiology images on CD.

**Request from Insurance and for Attorney's (without patient directive)**

There will be a charge for copies of medical records, when patients authorize release of such information to insurance companies, attorney/law offices, etc.

|                                     |
|-------------------------------------|
| Base Fee - \$19.58                  |
| Pages 1-10 \$ 1.29 per page         |
| Pages 11-50 \$ 0.66 per page        |
| Page 51 and higher \$ 0.27 per page |
| Plus actual Postage                 |

Patient will not be responsible for these charges. The requestors will receive an invoice from CIOX Health.

The Release of Information office is located at  
1015 Research Drive  
Toledo, OH 43614  
Phone: 419-383-4982  
Office hours; 8:30 to 4:30, Monday thru Friday.  
The HIM department contracts with Ciox Health

This message is intended for use only by the individual to whom it is addressed and may contain confidential patient and/or privileged information. If you are not the intended recipient, please take note that any dissemination, distribution or copying is not permitted. If you have received this communication in error, please notify us immediately by telephone (419) 383-4982 so that we might prevent any recurrence and return faxed material by U.S. Postal Service.

Thank you for your assistance

No objection to release to patient/parent     DO NOT release to patient/parent

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Print Name