

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 Information

Patient Name: Date of Birth:
Street Address: Medical Record Number:
City/State/Zip: Phone:
Email Address: Fax:

Send to Send from **Company/Organization:**
Street Address:
City/State/Zip: Phone:
Email: 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:

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

- 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 test 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.
- 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 patient information listed above) to:
- 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 taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for 180 days.
- 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.
- 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.
- UTMC may not condition my treatment or payment on my signing this document.
- I have been informed that The University of Toledo Medical Center 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.*
- A photocopy is as valid as the original.

Patient or Person Authorized to Consent Date

Patient Signature _____

Relationship to Patient

Office Use Only ID Verified: Yes No Date Received Date Processed

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



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Additional Information Regarding Your Request

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 - Requests for medical records generally take 7 to 10 working days to process: patient authorizations needs to be submitted for release of protected patient health information. 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 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:

If the record is delivered in paper. \$ 0.05 Per Page for supplies (paper and toner) plus \$ 0.90 Flat Labor Fee Plus actual Postage and tax

If the record is delivered electronically. Reproduction Fee & 6.50 plus tax

Radiology images on CD \$10.00 (charge by Radiology Department)

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
Pages 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 HealthPort, a copy service.

Confidentiality Notice

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 _____