AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

PATIENT NAME: ______________________________ **SS#:**_____________________ **DOB**: ___________

PATIENT ADDRESS: ________________________________ **PATIENT PHONE #:**______________________

INFORMATION RELEASE/EXCHANGED FROM:

LIMA MEMORIAL HOSPITAL
1001 BELLEFONTAINE AVE.
LIMA, OHIO 45804

DATE OF SERVICE: __________________________

INFORMATION RELEASED /EXCHANGED TO:

AGENCY: _______________________________
ADDRESS: ______________________________
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PHONE #:_______________________________

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SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED/OBTAINED:

( ) PARTIAL (PLEASE SPECIFY) _________________________
( ) ENTIRE CHART

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PURPOSE AND NEED FOR SUCH DISCLOSURE/INFORMATION:

( ) WORK ( ) AFTER CARE ( ) INSURANCE
( ) PERSONAL ( ) OTHER ____________________

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FORMAT REQUESTED: ( ) Hard Copy ( ) CD
( ) EMAIL (only pertains to release to third party)*****

If Hard Copy or CD, Do you wish to: ( ) PICKUP ( ) MAIL

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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION: I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release Lima Memorial Health System from all legal responsibility that may arise from this authorization. I hereby authorize _________________, or any physician(s) or medical personnel who have attended me to give __________________, or any authorized representative, any information or opinions requested from my medical records regarding my condition or treatment. Release of such information shall include any records of alcoholism, drug abuse, psychiatric diagnosis, HIV testing or treatment if provided. I expressly understand and agree that no liability of any nature shall be attached to either the above designated hospital, physician, or employees of said institution in acting upon this request. I also understand I have the right to revoke release after giving the hospital reasonable notice (at least 48 hours), however, this will not apply if the records have already been released in good faith. This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance therein, by the notification of Lima Memorial Hospital of my intention to do so.
This authorization (unless revoked earlier) expires of itself in one year or on this date: _________________

SIGNATURE OF AUTHORIZING PERSON: _____________________________________**DATE:**____________

IF AUTHORIZING PERSON IS A MINOR, -
SIGNATURE OF PARENT/GUARDIAN: _______________________________________**DATE:**____________ -

RELATIONSHIP: __________________________________ -
WITNESS: ___________________________________**DATE:** _________ **RELATIONSHIP**: _____________ -

***_____By initialing here, I understand and am willing to accept the risks involved with unsecured email communication of my protected health information.**

Notice: 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 permitted by the written consent of the person whom it pertains, or as otherwise permitted by 42 CFR Part 2 or a general authorization for release of information to criminally investigate or prosecute any alcohol or drug abuse client.

***Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties.**

NOTICE OF CANCELLATION:
Date: _____
Time: _____
Mode: _____
Signature of Person receiving notification: _____

Verification of Identification

License Verified: _____Initials of HIM Associate

Social Security Card Verified: _____Initials of HIM Associate

Other Form of Identification: _____Initials of HIM Associate

Signature of person picking records up, if not patient_____

Date picked up_____

Origin: Unknown
Revised: 3/03, 4/03, 2/04, 5/04, 4/12, 8/13, 10/13, 2/14, 3/14, 4/14