AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SITE ID _____

Fees may be charged in accordance with OHIO Revised Code: 3701.741 Fees for Providing Copies of Medical Records

Patient Name: _____ DOB: _____

Address: _____

I, _____ hereby grant my permission for a copy of the medical records pertaining to the patient above to be release from:

Unity Health Network Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please forward records to:

Physician/Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to be released: (Check applicable categories):

☐ Medical History, Examination, Reports	☐ Allergy Reports	☐ Surgical Reports
☐ Prescriptions	☐ Treatment or Tests	☐ Consultations
☐ Immunizations	☐ Laboratory Reports	☐ X-ray Reports
☐ Hospital Records Including Reports	☐ Other (Specify)	☐ Entire Record

Purpose for Need of Disclosure: (Check applicable categories):

☐ Continuity of Care	☐ Transfer of Care	☐ Patient Request
☐ Further Medical Care	☐ Insurance Eligibility/ Benefits	☐ Legal Investigation or Action
☐ Changing Physicians	☐ Personal	☐ Other (Specify)

From the following days of service /treatment _____ to _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be further disclosed without obtaining my authorization.

Unity Health Network may charge for the release of medical records according to the Ohio Revised Code. The charges are listed below and will be updated per the Ohio Revised Code annual adjustments. Some Unity Health Network offices use an agency to copy medical records and patients/patient representatives will be billed by the agency.

Please allow 7-14 business days for records to be processed and mailed/faxed.

Fees

☐ Request by patient or patient's personal representative:

- For the first ten pages: 3.18 per page
- For pages eleven through fifty: 66 cents per page
- For pages fifty-one and higher: 27 cents per page
- With respect to data resulting from an X-ray, MRI, or CAT scan, recorded on paper or film: 2.18 per page
- The actual cost of any related postage incurred by the healthcare provider or medical records company: Actual Cost

☐ Request By someone other than by patient or patient's personal representative:

- An initial fee which shall compensate for the record search:$19.58
- With respect to data recorded on paper or electronically, the following amounts:
- For the first ten pages: $1.29 per page
- For pages eleven through fifty: 66 cents per page
- For pages fifty-one and higher: 27 cents per page
- With respect to data resulting from an X-ray, MRI, or CAT scan, recorded on paper or film: 2.18 per page
- The actual cost of any related postage incurred by the healthcare provider or medical records company: Actual Cost

Your Rights With Respect To This Authorization:

Right to inspect or Copy the Health Information to be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting UHN's Privacy Officer. Right to Receive Copy of This Authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization**- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, Payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization**- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or receive a copy of my withdrawal, I may contact UHN's Privacy Officer at Unity Health Network, Attention Privacy Officer, 3033 State Road Suite 101, Cuyahoga Falls, Ohio 44223, or by telephone at (330) 923-5899 or via email at privacy@unityhealthnetwork.org. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good for 60 days.

I have had an opportunity to review and understand the content of this authorization for. By signing this authorization I am confirming that it accurately reflects my wishes.

Signatures of Patient or Legal Representative:

_____

Date_____

Relationship_____

(If signed by other than patient, state relationship and authority to do so)

A copy of this Release shall have the same authority as the original