



AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT HEALTH INFORMATION

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

If your provider is no longer with Unity Health Network – you may e-mail this completed form to medicalrecords@unityhealthnetwork.com or fax it to (330) 923-8090

Although email is a convenient way to communicate, most popular email services may not be encrypted. An unintended person may be able to access the information once it is transmitted over the internet. It is also possible that someone may be able to access your email account and read it. If you choose to send the medical records release authorization form to UHN via email, UHN will not be responsible for any unauthorized access to your personal information sent by email.

Provider Name: _____ Provider Phone: _____

Provider Address: _____ Provider Fax: _____

Name of patient/Previous name Date of birth/last 4 digits of SS#

Street Address City, State, Zip Code

Authorizes: Release of Protected Health Information To:

Name of Health Care Provider/Plan/Other:

Street Address City, State, Zip Code

Information to be released: (Check applicable categories):

<input type="checkbox"/> Medical History, Examination, Reports	<input type="checkbox"/> Allergy Reports	<input type="checkbox"/> Surgical Reports
<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Treatment or Tests	<input type="checkbox"/> Consultations
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Hospital Records Including Reports	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Entire Record

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

<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Transfer of Care	<input type="checkbox"/> Patient Request
<input type="checkbox"/> Further Medical Care	<input type="checkbox"/> Insurance Eligibility/ Benefits	<input type="checkbox"/> Legal Investigation or Action
<input type="checkbox"/> Changing Physicians	<input type="checkbox"/> Personal	<input type="checkbox"/> 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 2-3 weeks for records to be processed and mailed.

Fees

Request by patient or patient's personal representative:

- For the first ten pages: 3.62 per page
- For pages eleven through fifty: 76 cents per page
- For pages fifty-one and higher: 30 cents per page

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

- An initial fee which shall compensate for the record search: \$22.33
- With respect to data recorded on paper or electronically, the following amounts:
- For the first ten pages: \$1.47 per page
- For pages eleven through fifty: 76 cents per page
- For pages fifty-one and higher: 30 cents per page

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 that 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, 2750 Front Street Cuyahoga Falls, Ohio 44221, or by telephone at (234) 571-3650. 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
Updated 04/2023*