AVITA HEALTH SYSTEM

AUTHORIZATION TO RELEASE INFORMATION

OFFICE USE ONLY:

MRN_____

Released by_____ Date_____

PATIENT INFO:

Last Name_____ First Name_____ MI_____

Date of Birth_____Social Security No_____

Address_____ Phone Number_____

Responsible Party (if other than patient):

____ Parent ___ Guardian ___ Power of Attorney ___ Executor of Estate (probate court appointment required)

If responsible party is not the patient, a copy of legal documents MUST accompany the authorization when presented. The only exception is that of a parent of a minor child under 18 years of age.

DISCLOSE INFORMATION TO THE FOLLOWING__

Address_____ Phone_____ Fax/Email_____

INFORMATION TO BE DISCLOSED: Records Date of Service

_____

_____

_____

_____

PURPOSE OF DISCLOSURE:

__ Medical Treatment/Continuity of Care __ Employment Related __ Disability __ Insurance __ Legal Purposes

__ Adoption Planning __ Research Other: _____

This authorization for release of information for the date of service indicated above is effective until

(date) _____ or for a maximum of 60 days from the date signed below.

I understand the medical record may include information concerning testing, diagnosis or treatment of ABUSE, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC AND/OR DRUG/ALCOHOL TREATMENT that may be in my medical record.

I understand if the person or entity receiving the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

I understand that if I request my information be released via email, this method is unencrypted, and I accept the risk that it may be unsecure.

I understand that treatment, payment, enrollment or eligibility for benefits will not be impacted by not signing this form. Research-related treatment is strictly voluntary. I understand by signing this authorization it gives the researcher(s) the permission to use or disclose my personal health information for such research.

I understand there may be charges for copying and release of information and accept financial responsibility for those charges. As described in the Notice of Privacy Practices of Avita Health System, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Avita Health System in reliance on this authorization, by sending a written revocation to: **Avita Health System, Medical Records Department, 269 Portland Way S., Galion, OH 44833, Attn: Director of Medical Records.**

I HEREBY AUTHORIZE AVITA HEALTH SYSTEM TO DISCLOSE TO THE PARTY/PARTIES NAMED ABOVE INFORMATION FROM MY MEDICAL RECORD FOR THE REASONS AND TIME SPECIFIED.

AUTHORIZING SIGNATURE_____ DATE_____ TIME_____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.