

Patient Name (First, Middle, Last)	Date of Birth: ____/____/____	Last 4 digits of Patient's Social Security Number:	Telephone Number: ()
Patient's Address			
Dates of Service to Release (From): _____ (To): _____			
Specific Reports to be Disclosed:			
<input type="checkbox"/> Emergency Department Records	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Reports	
<input type="checkbox"/> Discharge Information	<input type="checkbox"/> Therapy Notes	<input type="checkbox"/> Pathology Reports	
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Plan of Care	<input type="checkbox"/> Radiology Reports	
<input type="checkbox"/> Consults/Assessment	<input type="checkbox"/> Operative/ Procedure Reports	<input type="checkbox"/> Other: _____	
Purpose of Disclosure: <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> Legal Reasons <input type="checkbox"/> Personal <input type="checkbox"/> Other:			
Release Information From:			
<input type="checkbox"/> James Cancer Hospital and Solove Research Institute	<input type="checkbox"/> Ohio State University Wexner Medical Center	<input type="checkbox"/> East Hospital	<input type="checkbox"/> Ross Heart Hospital
	<input type="checkbox"/> Brain and Spine Hospital	<input type="checkbox"/> OSU Harding	<input type="checkbox"/> University Hospital
	<input type="checkbox"/> Dodd Hall	<input type="checkbox"/> Other (Specify) _____	
Release Information To: <input type="checkbox"/> Other (specify recipient and complete address below)	Release Information To: <input type="checkbox"/> The Ohio State University Wexner Medical Center (specify provider) <input type="checkbox"/> James Cancer Hospital and Solove Research Institute (specify provider)		
_____ (Name)	_____		
_____ (Address)	_____		
_____ (Phone)	_____ (Fax)	_____	
_____ (Patient's email)	_____		
Based on regulatory requirements, a fee may be charged for copies of medical records. If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of The Ohio State University Wexner Medical Center and James Cancer Hospital and Solove Research Institute.			
I give the facility as indicated above and its employees and business associates, CIOX, permission to release my medical record, or parts of my record, as noted above and as defined in the designated record set. I understand that the information released may include treatment for physical and mental illness, alcohol or drug use, AIDS (Acquired Immunodeficiency Syndrome) or HIV testing. I know I need to sign a separate form to release any notes related to psychotherapy. This form is valid for one year unless I give written notice prior to the release of the information, as stated in the Notice of Privacy Practices.			
The information released as a result of this form may be re-disclosed by the recipient and may no longer be protected by federal or state privacy rules, such as HIPAA.			
I understand that treatment or payment for the care I have received at OSUWMC is not dependent on my signing this release, unless treatment is for research or the care was given to provide information to a third party.			
If I am requesting records related to substance use disorder, federal law prohibits further release of my information without my written consent and requires an additional specific form to be completed before the records are provided.			
_____ Signature of the Patient or Person Authorized to Consent		_____ Date Signed	
_____ Relationship if not the Patient		_____ Date Signed	
_____ Witness (optional)		_____ Date Signed	
Submit requests to one of the following: The Ohio State University Wexner Medical Center Medical Information Management 110 Doan Hall, 410 West 10th Avenue Columbus, Ohio 43210-1228 Phone: (614) 293-8657	East Hospital Medical Information Management W113 181 Taylor Avenue Columbus, Ohio 43203 - 1779 Phone: (614) 257-2544	The James Cancer Hospital and Solove Research Institute 1st Floor James Cancer Hospital James A061 460 West 10th Ave Columbus, OH 43210 - 2500 Phone: (614) 293-8657	



MS0001

- THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER
 - JAMES CANCER HOSPITAL AND SOLOVE RESEARCH INSTITUTE
- AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name:

Medical Record Number:

Date of Birth: