



## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME	LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER			DATE OF BIRTH
THE UNDERSIGNED HEREBY AUTHORIZE:			
<input type="checkbox"/> SUMMA HEALTH SYSTEM HOSPITALS / CUYAHOGA FALLS GENERAL HOSPITAL <input type="checkbox"/> OTHER: _____			
PROVIDE: <i>(Name of Person or Organization)</i>			
NAME			
STREET			
CITY		STATE	ZIP CODE

FOR THE FOLLOWING DATES OF SERVICE / TREATMENT: \_\_\_\_\_

**PURPOSE OF DISCLOSURE**

- |  |   |
|--|---|
| <input type="checkbox"/> Billing _____<br><span style="margin-left: 100px;">expires one year from signature</span>     | <input type="checkbox"/> Research _____<br><span style="margin-left: 100px;">no expiration</span>                     |
| <input type="checkbox"/> Personal _____<br><span style="margin-left: 100px;">expires one year from signature</span>    | <input type="checkbox"/> Fund Raising _____<br><span style="margin-left: 100px;">unless opt out, no expiration</span> |
| <input type="checkbox"/> Legal _____<br><span style="margin-left: 100px;">expires one year from signature</span>       | <input type="checkbox"/> Marketing _____<br><span style="margin-left: 100px;">unless opt out, no expiration</span>    |
| <input type="checkbox"/> Health Care _____<br><span style="margin-left: 100px;">expires one year from signature</span> | <input type="checkbox"/> Other _____  |

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence /abuse.

I understand that I am not required to sign this authorization form and that Summa Health System Hospitals / Cuyahoga Falls General Hospital will not condition the provision of treatment or payment to me on the signing of this authorization, except that Summa Health / Cuyahoga Falls General Hospital may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Summa Health / Cuyahoga Falls General Hospital may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal policy regulations.

I understand that I may revoke this authorization at any time by notifying Summa Health System Hospitals / Cuyahoga Falls General Hospital in writing, except to the extent that 1) action has been taken in reliance on this authorization; or 2) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

- Guardian
- POA
- Executor
- Person Responsible for Estate

(iv) A description of each purpose of the requested disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

(v) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "None," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including the creation and maintenance of a research database or research repository.

(vi) Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

(2) *Required statements.* In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

(i) The individual's right to revoke the authorization in writing, and either:

(A) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

(B) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by 164.520, a reference to the covered entity's notice.

(ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph

(b)(4) of this section applies; or

(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

(iii) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule.

(3) *Plain language requirement.* The authorization must be written in plain language.

(4) *Copy to the individual.* If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

**164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.**

A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosures and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this section.

(a) *Standard: Use and disclosure for facility directories.*

(1) *Permitted uses and disclosure.* Except when an objection is expressed in accordance with paragraphs (a)(2) or (3) of this section, a covered health care provider may:

<input type="checkbox"/> Pertinent Summary (includes all *items below if contained in the record)		
<input type="checkbox"/> Admission Form	<input type="checkbox"/> *Special Procedure	<input type="checkbox"/> Respiratory Report
<input type="checkbox"/> *Facesheet	<input type="checkbox"/> *Pathology report	<input type="checkbox"/> Medications / treatment report
<input type="checkbox"/> *Discharge Summary	<input type="checkbox"/> *Cardiac Cath Report	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> *Emergency Room Report	<input type="checkbox"/> *Lab Reports	<input type="checkbox"/> Entire Record
<input type="checkbox"/> *History & Physical	<input type="checkbox"/> *Radiology Report	<input type="checkbox"/> Other _____
<input type="checkbox"/> *Consultation Record	<input type="checkbox"/> *EKG Report	<input type="checkbox"/>
<input type="checkbox"/> *Operative Report	<input type="checkbox"/> *EEG Report	<input type="checkbox"/>