



Medical Record# _____

AUTHORIZATION TO DISCLOSE PHI (Protected Health Information)

1. PATIENT INFORMATION:

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Email: _____

2. PERSON OR COMPANY WHO WILL RECEIVE INFORMATION:

☐ Self (same info as above)

☐ Person or Entity: _____ Phone: _____

Address: _____ Fax: _____

Email: _____

3. TREATMENT LOCATION:

☐ Fisher-Titus Medical Center (Hospital) **Phone: 419-660-2702 Fax: 419-660-2709**

Fisher-Titus Family Medicine: Phone: 419-660-2734 Option 2 Fax: 419-660-2695

☐ Family Medicine Wakeman ☐ Family Medicine Milan ☐ Convenient Care ☐ Family Medicine New London

☐ Norwalk Primary Care ☐ Family Medicine Willard ☐ Family Medicine Bellevue

Fisher-Titus Specialty Offices: Phone: 419-660-2734 Option 2 Fax: 419-660-2695

☐ Gen. Surgery ☐ Digestive Health ☐ Endocrinology ☐ Executive Urology ☐ Pediatrics ☐ Women's Health

☐ Behavioral Health ☐ Occupational Health

4. PURPOSE OF REQUEST:

☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Other (specify): _____

5. INFORMATION TO BE RELEASED (check all that apply and include dates of service)

Records or Information:

☐ Discharge Summary (date) _____

☐ History & Physical (date) _____

☐ Consultation Report (list physician name & date) _____

☐ Operative Report (date) _____

☐ Laboratory Reports (list date/type of test) _____

☐ Pathology Reports (date) _____

☐ Radiology Reports (list date(s) or type(s) of reports) _____

☐ Radiology Images (list date(s) or type(s) of images) _____

☐ Therapy (OT, PT, SPH, AUD) (list date(s) or type(s) of therapy records) _____

☐ Immunization Record (date) _____

☐ Emergency Dept. Record (date) _____

☐ Clinic Visit-Specify Provider/Clinic (list date(s)/type(s) of record(s)) _____

☐ Other (please specify) _____

☐ Entire Record From: (date or date range) _____

☐ Billing Records (date(s) of the service) _____

☐ Any future records through one year of signature _____



6. FORMAT AND DELIVERY OF INFORMATION:

Format (Select only one) ☐ CD (Hospital only) ☐ Flash Drive ☐ Encrypted Email ☐ Paper

Delivery Method (select one only): ☐ Fax ☐ Mail ☐ In-Person Pick Up

7. Part II REVIEW AND APPROVAL:

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS, or other communicable diseases, drug or alcohol abuse, and / or reproductive health. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Alcohol/Drug Abuse Treatment/Referral
☐ Mental Health (other than Psychotherapy)

☐ Sexually Transmitted Disease
☐ HIV/AIDS Related Treatment

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Fisher-Titus Health will continue to provide treatment and seek payment for services provided. Fisher-Titus Health may charge a fee for providing the information specified above.

8. This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____

Signature

Printed Name

Date

REPRESENTATIVE (complete if signed by personal or authorized representatives)

Representative Full Name (Signature)

Date

Representative Full Name (Please Print)

Relationship to Patient

Witness Signature

Date