AUTHORIZATION: RELEASE OF INFORMATION FORM

- Administrative Use Only - Driver's license number:

CLI.1777 (Rev. 10/25)

ROIFRM

Patient Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize the use or disclosure of the above named individual's health information as described below:

☐ Adena Health System – including all locations ☐ Adena Retail Pharmacy ☐ Adena Medical Group
Provider: _____

To: _____ Release records to _____ Obtain records from _____ Exchange verbal information with

Name: _____

Address: _____

Dates of Service to Release – From: _____ To: _____
(Encounter must have been at the time of or prior to the signing of this authorization.)

_____ History & Physical
_____ Discharge Summary
_____ Operative / Procedure Report
_____ Consultations
_____ Psychotherapy (requires approval by psychotherapist)
_____ Abstract (Facesheet, History & Physical, Emergency Note, Discharge Summary, Consult, Test Results, Operative Note)
_____ All Test Results
_____ X-ray / Imaging CD
_____ X-ray / Imaging Report
_____ Emergency Room Report
_____ Clinic Notes
_____ Entire Record
_____ Itemized Bill
_____ Other (Check and specify below):_____
_____

Purpose of Disclosure: _____ Continuation of Medical Care _____ Insurance _____ Disability _____ Personal
_____ Legal Reasons (including trial preparation and court testimony)

I understand the following:

- That authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment.
- That once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
- That unless specified differently, this authorization will expire (date or event) _____ or if I fail to specify, this authorization will expire **one year** from the date of the signature.
- That I have the right to revoke this authorization at any time and that I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has been released in good faith prior to receipt of written revocation. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- That record copies will be released in paper format unless requested as electronic by initialing here _____. Please provide email for such: _____.
- ***That with the exception of records being copied for continuity of care, for insurance company or other third party reimbursement, there WILL be a charge for copies of records in accordance with Ohio Law.***

_____ /_____
Signature of Patient or Patient's Representative Time / Date

_____ /_____
Signature of Witness Time / Date

_____
Printed Name of Patient or Representative

_____
Printed Name of Witness

If signed by patient's representative, relationship to patient: _____
If patient representative, provide documentation or explanation of your authority to act for the patient. (Attach copy).

Attorney/Legal Office Use Only

If Attorney or Legal Office, please check if certification is required:

☐ Certification required