

**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