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Summa Health

Authorization for Release of Patient Health Information

Will expire in one year if not otherwise specified

Patient Name	LAST	FIRST	MIDDLE	Date of Birth

☐ Summa Health System - Akron Campus
Medical Records / ROI
525 East Market Street
Akron, OH 44309

☐ Summa Health System - Barberton Campus or
Wadsworth-Rittman Hospital (prior to 7/14/14)
Medical Records / ROI
155 Fifth Street NE
Barberton, OH 44203

RELEASE TO: *(Name of Person or Organization)*	PHONE:
NAME	

STREET	CITY	STATE	ZIP CODE

FOR THE FOLLOWING DATES OF SERVICE / TREATMENT:_____

☐ CHECK HERE IF SUBSTANCE ABUSE RECORDS (INPATIENT DETOX) ARE TO BE RELEASED

PURPOSE OF DISCLOSURE: ☐ Continuing Care ☐ Personal Use ☐ Legal ☐ 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 my records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. The health care provider named above may condition the provision of research-related treatment to me, if I am a research participant, on the signing of this authorization for the use or disclosure of my personal health information for such research. The health care provider named above may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosures to a third party on the signing of this authorization.

I understand that 42 CFR prohibits further disclosure by the recipient of the information that identifies a patient as having a substance use disorder. I also understand that other records may be redisclosed by the authorized recipient and no longer protected by federal regulations.

I understand that I may revoke this authorization at any time by notifying the health care provider named above 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.

I understand that there may be a fee charged to patients for copies of records as follows: Pertinent summary=free; Entire record on paper=$0.10/page; Entire record on CD/flash drive=$6.50. Non-patient requesters (attorneys, etc.) are charged based on amounts allowable by the Ohio Revised Code

FORMAT REQUESTED: ☐ Jump drive ☐ CD ☐ Paper Released by: (Initials) _____

☐ Pertinent Summary (includes all *items below if contained in the record)			
☐ *Facesheet	☐ *Consultation Record	☐ *Lab Reports	☐ Medications
☐ *Discharge Summary	☐ *Operative Report	☐ *Radiology Report	☐ Nurses Notes
☐ *Emergency Room Report	☐ *Pathology report	☐ *EKG Report	☐ Entire Record
☐ *History & Physical	☐ *Cardiac Cath Report	☐ Respiratory Report	☐ Other _____

_____ _____ _____
Signature of Patient Date Time

_____
Printed name of Patient or Legal Representative

_____ _____ _____
Signature of Patient's Legal Representative Date Time

☐ Guardian ☐ POA ☐ Executor ☐ Person Responsible for Estate

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