Student Health Services
The Ohio State University
1875 Millikin Road Columbus, OH 43210
Phone: 614-292-0118 Fax: 614-292-7042
Email: medicalrecords@osu.edu

Last	First	MI
ID#	(Place patient label here)	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please print. Incomplete forms will not be processed. See reverse side for instructions and fees.

1. PATIENT WHOSE INFORMATION IS TO BE RELEASED

Name _____
Last First Middle Initial Maiden/Other

Date of Birth _____ /_____ /_____ Preferred Phone Number _____
Month Day Year

2. PERSON/ORGANIZATION WHO IS RECEIVING OR RELEASING INFORMATION

I authorize OSU Student Health Services to:

☐ **Release** health information **to** ➡

OR

☐ **Obtain** health information **from** ➡

select only one

Name/Facility	
Address	
City/State/Zip	
Phone Number	
Fax Number **OR** Email	

3. TYPE OF INFORMATION TO BE RELEASED

☐ Office Visit Notes (includes Primary Care, Preventive Medicine, Allergy and Nutrition)
☐ Gynecology Notes ☐ Optometry Notes ☐ Dental Notes ☐ Dental Images ☐ Physical Therapy & Sports Medicine
☐ Radiology Reports ☐ Laboratory ☐ Immunizations ☐ Other (please specify): _____

4. DATES OF INFORMATION TO BE RELEASED

Information released will fall within this date range: _____ to _____ **Future dates of service will not be honored.**
Month/Day/Year Month/Day/Year

5. METHOD OF RELEASE

Information will be released by: ☐ Mail ☐ Fax ☐ Pick-Up ☐ Verbal/Phone ☐ Email ***select only one***

6. PURPOSE OF RELEASE

☐ Personal Use ☐ Continued health care ☐ Academics ☐ Employment ☐ Legal ☐ Other (specify): _____

7. PATIENT RIGHTS AND SIGNATURE

I understand that the information in my health record may include information relating to sexually transmitted infections (STI), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. I understand that this authorization is **valid for 365 days**, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand there may be a charge for record copies. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I selected email as the method of release, I understand that email is not a secure form of communication as email communication can be intercepted in transmission or misdirected. I understand that the choice to have my protected health information emailed is at my own risk. If I have questions about the disclosure of my health information, I may contact the Health Information Manager.

_____ _____ _____
Signature of Patient or Legal Representative** Date Legal Relationship
(****paperwork must be submitted with this request**) **(if not the patient)**

FOR OFFICE USE ONLY

Request received in HIS _____ on _____ by _____
Date HIS Staff Initials

Patient unable to sign: ☐ Minor ☐ Telephone Consent ☐ Other: _____

Request _____ on _____ by_____ ☐ Info provided at time of service ☐ Payment Received: _____
(mailed, faxed, etc.) Date Staff Initials/Service Area Date

INSTRUCTIONS

All sections must be completed in their entirety.

1. **Patient Information:** Complete the entire section to clearly and legibly identify patient - entire patient name (and any previous names), date of birth and phone number.

2. **Receiving Party**: Identify the full name/organization, address, phone and fax number of the recipient of your health information. Please allow 7-10 days for processing.
   - Select only one: Do you want to SHS to release information? **OR** Do you want SHS to obtain information?
   - If the requested release will be made by mail, provide the complete address.
   - If the requested release will be made by fax, provide the fax number.
   - If the requested release will be made by email, please provide the email address.

3. **Information to be Released**: Be very specific about the information you need released. For example, types of visits or the name of the physician or provider who treated you.

4. **Dates to be Released:** This can be a very specific date or more general. For example, July 15, 2012 or June 2012 - Feb 2013. You may not request future dates of service. For example, if you complete this form on June 1, 2014, you may not authorize the release of progress notes from an appointment that is scheduled on June 30, 2014.

5. **Method of Release:** How will your information be delivered? Select only one method and be sure to provide address, fax number or email address in section number **2** (see above).

6. **Purpose of Release:** Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

7. **Rights/Signature:** Your **handwritten** signature and date of form completion are required.

FEE SCHEDULE (In accordance with Ohio Revised Code 3701.742)

Physician/Healthcare Facility: (Records must be mailed/faxed to the provider listed)	No Charge
Personal Copy: (No charge for copies of immunization records)	$8.00
Third Party: (Not related to continuing care)	$8.00
Attorney and Insurance Company: (Including subpoenas/excluding claims processing)	$20.24 records search fee $1.34/per page (pages 1 – 10) $0.69/per page (pages 11 – 50) $0.27/per page (pages 51+)
Radiology and Dental Films: (No charge when requested by a physician)	$2.27/per film