KNOX COMMUNITY HOSPITAL
MOUNT VERNON, OHIO

Authorization to Use or Disclose Health Information

Patient Name: _____

Date of Birth: _____ Telephone Number: (_____)_____-_____

Address: _____
street city state zip

I authorize ☐ Knox Community Hospital
☐ Other Facility_____ } to use/disclose the health information of the above-named person as described below:

Date(s) of Service: _____

☐ Emergency Room Report ☐ Consultation ☐ Radiological Report
☐ Discharge Summary ☐ Operative Report ☐ Radiological Images (CD only)
☐ Laboratory Report ☐ History & Physical Exam ☐ Office Notes
☐ Other: _____

Note: Please specify the kind of information you are requesting by marking the appropriate boxes above. Requests for simply "Any / All" records cannot be accepted. Requests where you have checked or marked all of the boxes can take up to 30 days to complete and you will be contacted when your records can be picked up.

My health record may include information about sexually-transmitted disease(s), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse. I understand that the health information in my health record may contain documents from other healthcare providers used in part or in whole by the hospital or its affiliated clinical services.

This information may be disclosed to, at the request of the individual:

Name: _____ Fax/Phone: (_____)_____-_____

Address: _____
street city state zip

This information will be used for or by

☐ my personal records ☐ another healthcare provider ☐ other: _____

I understand that I have the right to revoke this authorization at any time, unless the information has already been released. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. Without revocation, this authorization will expire:

☐ when this request is completed ☐ in _____ days (not to exceed 365) ☐ when claim/case is final

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. Signing this form has no impact on healthcare treatment. I understand that part or all of my request for access to my health information may be denied if state or federal laws restrict such access. **(Reasons why my request for access may be restricted or denied are listed on the back of this page.)**

_____
date signature of patient or legal representative

If signed by a legal representative, please provide your relationship to the patient (i.e. guardian, power of attorney, executor) ***and any required documentation to support this relationship***.

_____
date signature of witness

See the back of this form to request Patient Portal access to lab and imaging results.
Copies of this authorization are available upon request.

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Patient Portal Access:
I request access to my health information via an internet portal. (Proof of identity is required.) My email address is: _____. I understand that this access applies only to hospital visits after March 25, 2014.

You need to know that we are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- If your access request is not signed by you or a valid representative.
- If your access request is signed by a representative and the representative has not provided information to us on the source of his/her authority to represent you.
- If we do not maintain the information you have requested to copy or inspect.
- If the information you have requested is not a part of your record.
- If your request is for psychotherapy notes.
- If your request includes information compiled for litigation.
- If your request includes information held by our laboratory that is not accessible by law.
- If your request includes information created or obtained in the course of research still in progress that includes your treatment, and you agreed to this denial of access when consenting to participate in the research.
- If a licensed health professional has determined that the requested access is likely to either endanger you or another person's health or safety or cause substantial harm to you or another person.
- If your request is to copy information and you are an inmate in a correctional facility (you still retain the right to inspect the information).
- If your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

For Hospital/Facility Use Only

Record components authorized for use or disclosure

Medical Record Number: _____ List Account#s

- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Laboratory Report
- ☐ Consultation
- ☐ Operative Report
- ☐ History & Physical
- ☐ Radiological Results
- ☐ Office Notes
- ☐ Other (please specify): _____

Indicate How the Information was Released:

☐ Patient pick-up ☐ Paper ☐ CD ☐ Thumbdrive
☐ Electronic Transfer (images to OhioHealth only) ☐ FollowMyHealth Portal ☐ RelayHealth Portal
☐ Telephone ☐ Fax Number: (_____)_____-_____
☐ US Mail ☐ Certified Mail (certification # : _____)
☐ Federal Express (tracking #: _____)
Other (please describe): _____

☐ Photo ID Attached ☐ Photo ID already on file

Was the patient offered a Privacy Notice? YES NO (circle one)

_____

date signature of hospital representative releasing health information