AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.

Patient name: _____ ID Number (if known): _____

Date of Birth: _____

Title and name of person releasing my health information:

_____

Person(s) receiving my health information [Example: "My employer"]:

_____

Description of information being disclosed for the following date(s) of service: _____
_____

[ ] Complete Health Record
[ ] History and Physical Exam
[ ] Progress Notes
[ ] Radiology Reports
[ ] Abstract/Pertinent Information
[ ] HIV/AIDS information
[ ] Drug and Alcohol treatment information
[ ] Other: _____
[ ] Discharge Summary
[ ] Consultation Reports
[ ] Laboratory Tests
[ ] Emergency Department Record

Purpose of the Disclosure [Example: "At the request of the patient"]:
_____

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

[ ] 1 year from the date in which I, or my legal representative, signs this authorization;

[ ] upon the happening of the following event: _____
_____ [Example: "Upon release of the above records"].

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Privacy Officer at 1325 Corporate Drive, Suite A, Hudson, Ohio 44236. I understand that my revocation won't have any affect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above: Yes _____ No _____.

_____ _____

Signature of Patient or Legal Representative Date

If signed by the patient's legal representative:

Printed Name of representative: _____

Relationship to the patient: _____

- PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD -

PATIENT'S RIGHT TO ACCESS AND/OR COPY HEALTH INFORMATION

POLICY: The Practice shall afford individuals the right to access, inspect, and obtain a copy of their health information in accordance with the provisions of the HIPAA Privacy Rule.

PROCEDURE:

1. Request for Access and/or Copying Form. An individual who seeks to access and/or copy his or her health information, must complete the form entitled "Patient's Request to Access and/or Copy Health Information" and submit it to the Privacy Officer. The individual can obtain the form from the Privacy Officer.

   The completed form should be forwarded to the Privacy Officer who will then decide whether to grant or deny the individual's request in accordance with the rules set forth in this policy.

2. The Privacy Officer shall respond to the request within 30 days if the information sought is on-site and 60 days if the information is off-site. The Privacy Officer may extend the deadline once for no more than 30 days by providing the patient with a written statement of the reasons for the delay and the date in which the Privacy Officer will complete the request.

   The Privacy Officer will notify the individual of where to direct his or her request for access if the Practice does not maintain the information sought but knows where it can be obtained.

3. Granting Access. If the Privacy Officer grants access, he or she will provide the individual with access to the records in the form requested (unless not producible in such a form) and the chance to copy the records. The Privacy Officer may provide the individual with a summary of the information requested if the individual agrees in advance to this method and the fees associated with the summary.

4. Denying Access

   The patient/legal representative is entitled to written notice of a denial. The patient/legal representative may request a review of some denials, others are not reviewable.

   a. Unreviewable - An individual has no right to access the following information and the Privacy Officer does not have to provide the individual with a chance for review:

      i. Psychotherapy notes (if denying for this reason, first consult with the Privacy Officer)

      ii. Information compiled in anticipation of civil, criminal, or an administrative action or proceeding.

iii. Health information that is subject to CLIA to the extent the provision of access to the individual would be prohibited by law.

iv. Health information that was obtained from another person (other than a health care provider) under a promise of confidentiality and granting access would likely reveal the source's identity.

b. Reviewable – The Privacy Officer may deny access for the following reasons but must give the individual a chance to seek a review of the denial:

i. A physician chosen by the Practice has determined that access is likely to endanger the life or safety of the patient or another individual.

ii When the health information sought makes reference to another person and a physician chosen by the Practice determines that access is likely to cause harm to that person.

iii. When the request for access is made by a personal representative and a physician chosen by the Practice determines that providing access to the representative is likely to cause harm to the patient or another person.

If the patient/legal representative requests a review, a physician chosen by the Practice who was not involved in the original denial must determine, within a reasonable period of time, whether the denial was proper and provide written notice to the determination to the requestor.

c. Denial Notice - If you deny access *for any reason*, you must provide the patient with a written denial using the form entitled "Response to Patient's Request to Access and/or Copy Health Information," which includes (a) the basis for the denial, (b) a statement of the individuals right to have the denial reviewed and how such right may be exercised, and (c) a description of how the individual can file a complaint with the Practice and the Secretary of Health and Human Services. The description must include the name (or title) and telephone number of the person or office responsible for receiving complaints.

5. You must document and retain (a) the records that are subject to access and (b) the title of the person or office responsible for processing the request for access for 6 years.

PATIENT'S REQUEST TO ACCESS AND/OR COPY HEALTH INFORMATION

Please complete the following:

1. Name of Requestor (print): _____

   Patient name (if different): _____

   Patient's birth date: _____
2. Address: _____
3. Phone: _____
4. If you are not the patient, your relationship to the patient: _____

   _____
5. Do you wish to [ ] access (e.g. review) the health information, [ ] a copy of the health information or [ ] both.
6. Describe the information you want to access (e.g., lab test results, physician notes): _____

   _____
7. Identify the date(s) of information you want access to (e.g., date of office visit, treatment, or other health care services): _____

   _____

There is no charge to access your health information. If you would like a copy of the information, we will charge a reasonable fee for the copying, postage, and to prepare a summary (if you request a summary). We will inform you by [ ] phone [ ] letter (pick one) of the cost of your copy before we make the copy and verify that you agree to pay for the copy. We will require you to pay for your copy before you receive it. We will notify you in writing within 30 days of your request (60 days if the health information requested is not maintained or accessible on-site) if and when your health information will be available for access, where you will need to come to access your health information to read and review it, or where to come to pay for and pick up your copy. We will notify you within 30 days if we need one additional period of 30 days to respond to your request. In specific circumstances, we may deny access to your health information, or to a portion of your health information. If we deny access we will return this form to you with our written reasons for our denial and explain your right to review the denial, if applicable. The Practice reserves the right to supervise your access.

_____ _____

Signature of patient or legal representative Relationship to the patient

Date: _____

- Submit this request form to the Privacy Officer -