The University of Toledo Medical Center
Health Information Management
Release of Information Unit
1015 Research Drive, Toledo, OH 43614
Phone: 419-383-4982
Fax: 419-383-3001

Authorization to Release Copies of a Medical Record

Please complete this form in **its entirety** so we can help you receive the information you are requesting.

Patient Information

Patient Name: Date of Birth:

Street Address: Medical Record Number:

City/State/Zip: Phone:

Email Address: Fax:

☐ Send to ☐ Send from **Company/Organization:**

Street Address:

City/State/Zip: Phone:

Email: Fax:

Purpose of release/disclosure to other person/organization:

☐ Continuity of Care ☐ Request of Patient ☐ Other (Specify)

☐ Outpatient Surgery Date of Service ☐ Clinic or Office Visit Date of Service

☐ Inpatient Admission Date of Service ☐ Emergency Department visit Date of Service

Information to be released: (check all that apply)

☐ Discharge Summary ☐ Emergency Department Reports ☐ Radiology/Ultrasound Reports ☐ Billing

☐ History & Physical ☐ Physician Progress Notes ☐ Laboratory Reports ☐ Complete Set of Medical Records

☐ Operative Reports ☐ Psychiatric Health Record

☐ Other:

Information to Be: ☐ Electronic Delivery (see instructions on back) ☐ Pick Up ☐ CD ☐ Paper copy ☐ Mailed

1. I hereby authorize The University of Toledo Medical Center (UTMC), its Agents and its Employees to release Protected Health Information about me/my child to the recipient which may include test results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information if any.
2. I am the patient, or the legally authorized representative of the patient, listed above. I request The University of Toledo Medical Center to release my protected health information (or the patient information listed above) to:
3. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for 180 days.
4. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
6. UTMC may not condition my treatment or payment on my signing this document.
7. I have been informed that The University of Toledo Medical Center utilizes an outside contracted copy service. I have been informed that copies of my medical record(s) are subject to a copying fee *Please see second page regarding our fee schedule.*
8. A photocopy is as valid as the original.

Patient or Person Authorized to Consent Date

Patient Signature _____

Relationship to Patient

Office Use Only ID Verified: Yes No Date Received Date Processed

Information: Mailed Picked Up Faxed Processed By: HIM Staff Other: