PROTECTED HEALTH INFORMATION

AUTHORIZATION FOR RELEASE

Lima Memorial HEALTH SYSTEM

Affiliate of ProMedica

Patient Name _____ **Date of Birth** ___/___/___
First Middle Initial Last

Patient Address _____ **Phone** _____
Street City State Zip Code

Social Security Number _____ **Email** _____
This will be added to your demographic profile in our system and will not be used for solicitation.

INFORMATION RELEASED/ EXCHANGED FROM:

Lima Memorial Health System
1001 Bellefontaine Avenue
Lima, Ohio 45804

INFORMATION RELEASED/ EXCHANGED TO:

Name _____
First Middle Initial Last

Address _____
Street City State Zip Code

Phone _____ **Relationship to Patient** _____

INFORMATION TO BE RELEASED:

- ☐ **Entire Medical Record**
- ☐ **Partial Medical Record (Please Specify):**
- ☐ **Opt-Out of Physician Health Information Exchange**
- ☐ **Billing Information** _____

PURPOSE AND NEED FOR INFORMATION:

☐ **Work** ☐ **After Care** ☐ **Insurance** ☐ **Personal** ☐ **Other** _____

FORMAT REQUESTED: ☐ **Hard Copy** ☐ **CD** ☐ **Email (Only pertains to release to third party)***

IF HARD COPY OR CD, DO YOU WISH TO : ☐ **Pick Up** ☐ **Mail**

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION: I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release Lima Memorial Health System from all legal responsibility that may arise from this authorization. I hereby authorize _____ , or any physician(s) or medical personnel who have attended me to give _____ , or any authorized representative, any information or opinions requested from my medical records and billing information regarding my condition or treatment. Release of such information shall include any records of alcoholism, drug abuse, psychiatric diagnosis, HIV testing or treatment if provided. I expressly understand and agree that no liability of any nature shall be attached to either the above designated hospital, physicians or employees of said institution in acting upon this request. I also understand I have the right to revoke release after giving the hospital reasonable notice (at least 48 hours); however, this will not apply if the records have already been released in good faith. This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance therein, by the notification of Lima Memorial Hospital of my intention to do so.

Lima Memorial Medical Records
1001 Bellefontaine Ave, Lima, OH 45804 | 419.226.5025 | MedicalRecordsRequest@LimaMemorial.org

PROTECTED HEALTH INFORMATION

AUTHORIZATION FOR RELEASE

Lima Memorial HEALTH SYSTEM

Affiliate of ProMedica

This authorization (unless revoked earlier) expires of itself in one year on this date ____/____/____

Signature of Authorizing Person _____ **Date** ____/____/____

If Authorizing Person is a Minor,
Signature Of Parent/Guardian _____ **Date** ____/____/____

Relationship to Patient _____

Witness _____ **Date** ____/____/____

Relationship to Patient _____

_____ ***By initialing here, I understand and am willing to accept the risks involved with unsecured email communication of my protected health information.**

NOTICE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is permitted by the written consent of the person with whom it pertains, or as otherwise permitted by 42 CFR Part 2 or a general authorization for release of information to criminally investigate or prosecute any alcohol or drug abuse client.

***Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties.**

NOTICE OF CANCELLATION:

Date ____/____/____ **Time** _____ **Mode** _____

Signature of Person Receiving Notification _____

VERIFICATION OF IDENTIFICATION:

License Verified _____ **Initials of HIM or Financial Services Associate**

Social Security Card Verified _____ **Initials of HIM or Financial Services Associate**

Other Form of Identification Verified _____ **Initials of HIM or Financial Services Associate**

Signature of Person Picking Records Up, if Not Patient _____ **Date Picked Up** ____/____/____

Lima Memorial Medical Records
1001 Bellefontaine Ave, Lima, OH 45804 | 419.226.5025 | MedicalRecordsRequest@LimaMemorial.org