



THE UNIVERSITY OF TOLEDO  
MEDICAL CENTER

# Patient Authorization for Release of Information

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

### Patient Information

### Recipient Information

<b>Patient Name:</b> _____	<b>Recipient Name:</b> _____
<b>Birth Date:</b> _____ <b>SS#</b> _____	<b>Address:</b> _____
<b>Med Record Number (optional):</b> _____	_____
<b>Address:</b> _____	_____
_____	<b>Phone :</b> _____
<b>Phone:</b> _____	

1. I hereby authorize 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. Information To Be Disclosed: (check all that apply)

- |   |                        |
|---|------------------------|
| <input type="checkbox"/> Outpatient Surgery         | Date of Service: _____ |
| <input type="checkbox"/> Inpatient Admission        | Date of Service: _____ |
| <input type="checkbox"/> Clinic or Office Visit     | Date of Service: _____ |
| <input type="checkbox"/> Emergency Department Visit | Date of Service: _____ |

Specific Reports To Be Disclosed: (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Discharge Summary           | <input type="checkbox"/> Radiology/Ultrasound Reports    |
| <input type="checkbox"/> History and Physical        | <input type="checkbox"/> Pathology Reports               |
| <input type="checkbox"/> Operative Reports           | <input type="checkbox"/> Laboratory Reports              |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Physician Progress Notes        |
| <input type="checkbox"/> Psychotherapy Notes         | <input type="checkbox"/> Complete Set of Medical Records |
| <input type="checkbox"/> Other: _____                |  |

3. Purpose of Disclosure:  Continuation of Care  Request of Patient Other (specify) \_\_\_\_\_

4. Information To Be:

- |   |                                 |
|---|---------------------------------|
| <input type="checkbox"/> Copied and Mailed    | <input type="checkbox"/> Viewed |
| <input type="checkbox"/> Copied and Picked Up | <input type="checkbox"/> Shared |

- 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 revoke, this authorization is valid for 60 days.
- 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.
- 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.
- UTMC may not condition my treatment or payment on my signing this document.
- I have been informed that copies of my medical record(s) are subject to a copying fee. I have been informed that the UTMC utilizes an outside contracted copy service.
- A Photocopy is as valid as the original.
- Date of next appointment if known: \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_ (Witness Optional) \_\_\_\_\_ Date \_\_\_\_\_  
 (Patient or Person Authorized to Consent) (Relationship to patient and authority to act in the patient's behalf)

