KENT STATE UNIVERSITY | DeWeese Health Center

Health Information Management System
1500 Eastway Drive Kent, Ohio 44242
Phone: 330-672-8249 – Fax: 330-672-2272

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORATION

Patient's Name: _____Date of Birth: _____
Address:_____ City/State/Zip:_____
SSN# _____Phone#: _____E-mail:_____ _

Check Appropriate Box

☐ I authorize the DeWeese Health Center to **OBTAIN** information from:	**OR**	☐ I authorize the DeWeese Health Center To **RELEASE** information to:
_____ Name of Provider or Facility		_____ Name of Person, Provider, or Facility
_____ Address		_____ Address
_____ City/State/Zip		_____ City/State/Zip
_____ Phone # (include area code)		_____ Phone # (include area code)
_____ Fax#:		_____ Fax#:

PURPOSE FOR THIS REQUEST: (CHECK ONE) ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Continuity of Care ☐ Transfer of Care ☐ Legal ☐ Other

Check Item(s) Needed Below ☐ **Mail** ☐ **Pick Up** ☐ **Fax** ☐ **Email**

Information to be obtained/released			**Date(s) of Service**
□ Office Visit Notes	□ Emergency/Urgent Care Visit	□ HIV-Related Information	From: _____
□ Physical Exam	□ Radiology Reports	□ Alcohol/Drug Abuse-Related	
□ GYN Records	□ Immunizations	□ Other: _____	To: _____
□ Laboratory Tests	□ Physical Therapy Notes	_____	
□ Complete Chart	□ Verification of Visit	_____	

I understand that fees will apply for records consisting of more than 3 pages. There is no charge for copies of immunization records or TB skin test results. I understand that all fees must be paid in advance.

Release format: _____Written _____Verbal

- This release will expire in 90 days. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.
- This consent for release does not extend to records pertaining to **Psychological Services**.
- I understand that I signed this authorization form voluntarily.
- I am entitled to a copy of this completed authorization form.
- A copy of this authorization form is as valid as the original.

Signature: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.I understand that it is possible that the facility/person that receives the records may re-disclose the information ,therefore (1)KSU DeWeese Health center and its staff have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule(HIPAA) however, such information is always protected by the drug and alcohol regulations.

ROI-Rev: 2016/6 cp ; reviewed 07/2019 jv; revised 2022/05 ld; revised 2022/12 ld

STAFF USE ONLY:

To be completed by an employee of the DeWeese Health Center

Date Request Received: _____Received by: _____

Circle One: Records Mailed Records Picked Up Records Faxed Records Denied

Fee $: _____ Correspondence Received: _____

Employee Signature: _____Date Request Completed: _____