PROMEDICA PHYSICIAN GROUP
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Attachment B

Patient Name: ____ **Social Security #:** __________________

Patient Address: ____ **Date of Birth:** ____________________

____

Physician/Organization authorized to DISCLOSE information (from):

____

Person/Physician/organization authorized to RECEIVE the information (including address) (to):

____

____

Information to be disclosed (include dates where appropriate):

❑ **Entire Record (standard two years of information will be transferred, unless otherwise indicated below)**

OR

❑ Problem list ______________________________

❑ Progress Notes ___________________________

❑ X-rays/EKGs _____________________________

❑ Billing Statements ________________________

❑ Immunization Record ___________________________

❑ Laboratory Reports _____________________________

❑ Living Will ____________________________________

❑ Other (specify) _________________________________

Purpose of this disclosure

❑ Continuation of medical care

❑ Substantiation of payment claims

❑ Attorney

❑ Personal use

❑ Other (specify) ____

Information should be delivered via (select one)

❑ I will inspect and review the record on-site ❑ Mail to address above ❑ Fax to: __________________

❑ Pick-up (provide name of individual picking up information): ____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, this authorization will expire in one year. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.

Signature of Patient or Legally Authorized Representative: ______________________________ **Date:** _________

Relationship to Patient: _________________________ **Witness:** ____

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)

❑ Parent

❑ Legally Authorized Representative

❑ Durable Power of Attorney for Health Care

❑ Personal Representative of the Estate

❑ Other (specify and attach proof): ____

***If you transfer your medical records to a non-ProMedica Physician Group (PPG) physician, you will incur a charge. The bill will come from a third-party copying service. Transfer of records within PPG is free of charge to the patient if through no fault of, or not caused by the patient.**

To find a PPG physician, call 1-800-PPG-DOCS (1-800-774-3627) or visit www.ppgdocs.org.

***Please see the enclosed letter to discuss what is the cost of my medical record.**

WHOSE MEDICAL RECORD IS IT?

WHY DO I HAVE TO PAY FOR MY MEDICAL RECORD?

Increasingly, patients requesting their medical record for personal use or other use are being charged a fee. Why?

By law the ORIGINAL MEDICAL RECORDS are the property of and must remain within the keeping of the facility that created them.

The INFORMATION contained in each individual record is the property of that patient.

However, since the original record must be retained by the facility, they can be viewed at no cost but to create a second or third set that original must be reproduced via copying or scanning technology. Regardless of the method used, there is no way to produce a free copy.

Requests for medical records are generated entirely from outside the medical facility. To reproduce them requires compliance with federal regulations pertaining to confidentiality, use of supplies, equipment and knowledgeable labor. That means either the medical staff or a specialized outside service must handle each request. In today's cost conscience environment, it is entirely reasonable and customary to forward the cost of reproduction on to the requestor.

Patients are charged for the reproduction of their medical records and that cost is for producing and delivering of copies. Rates charged are governed by and set by the Ohio state law (House Bill 3701.741). Rates meet HIPAA standards and recommendations. Fee's are as follows:

Pages 1-10	$2.84 per page
Pages 11-50	$0.57 per page
Pages 51 and up	$0.24 per page

Plus actual postage and tax

***If you are changing physicians, you should discuss with your new physician what part of your medical record they require to minimize the out of pocket cost to you.**