PRINT FORM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FAMILY NAME: _____

To request medical records for yourself or your living relatives, this form should be completed by the individual for whom records are requested. For deceased relatives, this form should be completed by the individual's next of kin or the executor of the estate.
Medical records are requested for:

_____ born on _____ SS#: _____
Last Name First Name Middle Initial Month / Day / Year

who is: (check one) ☐ Living ☐ Deceased If deceased, please include date of death: _____
Month / Day / Year

From:
- ☐ The Ohio State University Medical Center
- ☐ James Cancer Hospital
- ☐ The Ross Heart Hospital
- ☐ Clinic
- ☐ Other [Provide the name, city, and state of the hospital(s) where treated.] _____

_____

_____

The following medical information regarding my hospitalization, care and/or treatment on the following dates:

_____ to _____ as an ☐ Inpatient ☐ Outpatient ☐ Emergency Dept.

Please provide my:
☐ Surgical report ☐ Pathology report ☐ Chart summary ☐ Paraffin-embedded tumor block & matching H & E slide

Pertaining to the diagnosis of: _____

Purpose of Disclosure: CONFIRMATION/DOCUMENTATION

Please release and furnish to: **Judith A. Westman, MD/ Doreen M. Agnese, MD/ Kandamurugu Manickam, MD**
Clinical Cancer Genetics & Medical Genetics Programs
2001 Polaris Parkway
Columbus, OH 43240
Fax: (614) 293-2314

I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo, or video has been designated above, if applicable. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 60 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. **The revocation of this authorization is effective except as indicated inOhioStateUniversityHealth System's Notice of Privacy Practices. Information released by the authorization may no longer be protected by federal privacy rules, such as HIPAA.** I understand that Ohio State University Medical Center cannot condition my treatment or payment for health care on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules Prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ _____
Signature of Patient or Next of Kin (Relationship to Patient) Date

_____ _____
Witness Date

Please Contact the Clinical Genetics Office at (614) 293-6694 or Toll-Free: 1-888-329-1654 if you have any questions

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