OPTOMETRY SERVICES

Medical Records

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1664 Neil Avenue Columbus, OH 43201 Phone: (614) 292-2020 Fax: (614) 247-6626 Email: OPT-medrec@osu.edu

Please print in Black or Blue ink. Incomplete forms will not be processed. See reverse side for instructions.

1. Patient whose information is to be released

Name _____ _____ _____ _____
Last First Middle Initial Maiden/Other

Date of Birth _____ (month / day / year) Preferred Phone Number _____

2. Person / Organization who is receiving or releasing information

I authorize Ohio State Optometry Services to:

☐ **Release** health information **to**

OR

☐ **Obtain** health information **from**

**select only one*

Name/Facility _____

Address _____

City/State /Zip _____

Phone Number _____ Fax Number _____

Email _____

3. Type of information to be released

☐ Office Visit Notes ☐ Images / Visual Fields ☐ Other (please specify):_____

4. Dates of information to be released

Information released will fall within this date range: _____ (month / day / year) to _____ (month / day / year)

5. Method of release

Information will be released by: ☐ Mail ☐ Fax ☐ Pick-up ☐ Email ***select only one**

6. Purpose of release

_____

7. Patient rights and signature

- I understand that this authorization is **valid for 90 days**, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.
- If I selected email as the method of release, I understand that email is not a secure form of communication as email communication can be intercepted in transmission or misdirected. I understand that the choice to have my protected health information emailed is at my own risk.
- I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization. Please refer to the Optometry Services Notice of Privacy Practices for additional information regarding revocation and disclosure of PHI.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed.
- I understand that certain records requests, such as those involving the creation of summary letters, are subject to preparation fees. I agree to pay the preparation costs associated with my Release of Information Request at the rate of $40 for every full 30 minutes the doctor works and completes the letter.
- Optometry Services will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization.

_____ _____ _____
Signature of Patient or Legal Representative** Date Legal Relationship *(if not the patient)*
*(**paperwork must be submitted with this request)*

For office use only

Request received _____ by _____
Date Staff Initials

Request _____ on _____ by _____
(mailed, faxed, etc.) Date Staff Initials/Service Area

THE OHIO STATE UNIVERSITY
COLLEGE OF OPTOMETRY

Revised 1/2023

INTRUCTIONS - All sections must be completed in their entirety.

1. **Patient Information**
   Complete the entire section to clearly and legibly identify patient - entire patient name (and any previous names), date of birth and phone number.

2. **Receiving Party**
   Identify the full name/organization, address, phone and fax number or email address of the recipient of your health information. Please allow 7-10 days for processing.

   - Select only one: Do you want to release information? OR
     Do you want Ohio State Optometry Services to obtain information?
   - If the requested release will be made by mail, provide the complete address.
   - If the requested release will be made by fax, provide the fax number.
   - If the requested release will be made by email, please provide the email address.

3. **Information to be Released**
   Check mark what you'd like to be released and/or add any additional records in the *Other* field. Be very specific about the information you need released.

4. **Dates to be Released**
   This can be a very specific date or more general. For example, *July 15, 2012* or *June 2012 - February 2013*. Please note that the expiration date is 90 days from when the Release of Information form was signed. Dates after the expiration date will not be honored.

5. **Method of Release**
   How will your information be delivered? Select only one method and be sure to provide the address, fax number or email address in section number 2 (see above).

6. **Purpose of Release**
   Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request.

7. **Rights/Signature**
   Your **handwritten** signature and date of form completion are required.