OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

OHC AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information

Authorization to release the protected information of:

Patient Name: _____

Current Address: _____

Last 4 digits of Social Security Number: _____ Phone Number: _____-_____-_____

Date of Birth: _____/_____/_____

Recipient Information

This authorization is to release the protected health information to:

Individual or Healthcare Provider Name: _____

Address: _____

Phone Number: _____-_____-_____ Fax Number: _____-_____-_____

Attention: _____

This authorization is to release protected health information from Oncology Hematology Care, Inc. This Includes information and records of any treatment or examination rendered during the period specified below, including, but not limited to diagnosis(es), HIV testing, mental health, abusive behavior, or substance abuse, if applicable.

The purpose of this authorization to use or disclose protected health information is to:

□ Personal use by patient □ Provide the requested information to the Healthcare Provider listed above

□ Legal □ Other (please specify) _____

Release the following information:

□ Diagnostic Reports □ Itemized Billing Statement □ Laboratory Reports

□ Other (please specify) _____

□ All Treatment Records

Date(s) of Service

□ All Dates of Service □ Date Range from: _____/_____/_____ to _____/_____/_____

(month-day-year)(month-day-year)

This authorization will expire 180 days from the date signed unless otherwise specified below:

□ On the following date: _____/_____/_____ □ When the following event occurs: _____

I understand that:

- Every effort will be made to fulfill my request as soon as possible, but may take up to 30 days to process.
- This authorization will remain in effect until the authorization expires or I provide a written notice of revocation to OHC's Privacy Officer at 5053 Wooster Road, Cincinnati, Ohio 45226. If I revoke this authorization, OHC may not be able to reverse the use and disclosure of the health information while the authorization was in effect.
- OHC will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.
- Once OHC discloses my health information by my request, it cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.
- OHC will provide your health information for a reasonable, cost – based fee.

Patient or Personal Representative Signature: _____ Date: _____

Print Personal Representative Name (please attach applicable legal documentation): _____

Relationship to Patient: _____