MetroHealth

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MAIDEN / OTHER NAME(S)	METROHEALTH MEDICAL RECORD #

CURRENT ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY #	PHONE #	EMAIL ADDRESS
		( )	

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ❒ MEDICAL TREATMENT
- ❒ DISABILITY
- ❒ INSURANCE
- ☒ LEGAL
- ❒ PERSONAL
- ❒ OTHER: (please specify) _____

3. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM (check as applicable):

❒ THE METROHEALTH SYSTEM ❒ SPRY ❒ OTHER: (please describe) _____

INFORMATION TO BE DISCLOSED (check as many as applicable):

- ❒ Office Visits
- ❒ Emergency Depatment Reports
- ❒ Test Results (labs, pathology, radiology)
- ❒ Cardiac Reports
- ❒ History & Physical
- ❒ Dischage Summary
- ❒ Operative Report
- ❒ Consultations
- ❒ Physical/Occupational Therapy Reports
- ❒ X-Ray Images
- ❒ All Reports Listed
- ❒ Other: (please describe) _____

4. ACTIONS TO TAKE

RELEASE INFORMATION TO:

P&G Reporting, LLC

NAME OF RECIPIENT		
29550 Detroit Road, Suite 203	Westlake, Ohio	44145
ADDRESS	**CITY/STATE**	**ZIP**

PHONE NUMBER	FAX NUMBER
(216) 870-2218	(216) 803-6008

INFORMATION SHOULD BE DELIVERED ON (select one):

❒ **Paper** ❒ **Compact Disc (CD)** ❒ **Secure Electronic Delivery (If electronic, provide recipient's email)** ❒ **Fax**

❒ **Mail to the above address** ❒ **Picked-up by:**_____**(ID is required for pick-up)** ❒ **Release to MyChart**

I, the undersigned, authorize The MetroHealth System to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. * Release of Psychotherapy Notes requires a separate authorization. This authorization and consent will expire 1 (one) year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

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MetroHealth

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After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information as per Ohio Revised Code 3701.741. There is no charge to send records directly to my health care provider for continuing care purposes.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.
I understand that The MetroHealth System 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 pary.

_____ / _____ _____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____

Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to one of the following:

1. The MetroHealth System
   Health Information Management Department – G-108
   2500 MetroHealth Drive
   Cleveland, Ohio 44109

2. Fax: (216) 778-2413

3. Additional Authorization Forms and Ohio fee schedule for medical record copies can be found at: https://www.metrohealth.org/requesting-copies-of-medical-records or call the Release of Information Office (216) 778-4252