



NWO Family Medicine

Authorization for the Release of Protected Health Information From Outside Physicians/Facilities

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Patient Address: _____

I, _____, hereby authorize _____
(Patient/Patient Representative) (Physician/Facility)

to disclose protected health information to Northwest Ohio Family Medicine for the purpose of continuity of care and treatment. The specific protected health information to be faxed to Medical Records at 419-427-3034 includes: _____

Expiration of Authorization: This authorization expires _____ (enter date or event). Unless otherwise noted, this authorization will expire 12 months after the date of the signature on this form.

My Rights: I may revoke this authorization at any time, provided I do so in writing and submit it to Northwest Ohio Family Medicine. The revocation will take effect when it is received. I also understand that revocation will not apply to information that has already been released in response to this authorization.

This authorization is voluntary. Failure to provide authorization can not be used as a condition to deny treatment unless a.) It is research related treatment. b.) Used for eligibility or enrollment in a health plan. c.) The determination of an entity's obligation to pay a claim. d.) Creating health information to provide to third party.

Notice: Northwest Ohio Family Medicine is required by law to keep your health information confidential. If you give authorization to disclose information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

Authorization: I authorize Northwest Ohio Family Medicine to release the health information for myself/patient listed above to the person/facility listed per the instructions outlined in this request. By signing below, I understand and acknowledge the following: 1.) I have read and understand this authorization and 2.) If I have any questions about disclosure of my protected health information, I may contact Matt Boehm, NWOHP Privacy Officer. I have the right to a copy of this request.

Signature of Patient or Patient Representative

Date

Printed Name

Relationship/Authorization (if other than Patient)

Staff Initials Receiving Signature: _____