CINCINNATI Breast Surgeons
A division of Seven Hills Women's Health Centers

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO CINCINNATI BREAST SURGEONS

Name of Facility/Provider to Release Medical Records: _____

Address of Facility/Provider to Release Medical Records: _____

Phone Number (_____) _____ _____

Fax Number (_____) _____ _____

I hereby authorize the above named Facility/Provider to release medical records in its possession, including information regarding my medical condition and treatments I have received to Cincinnati Breast Surgeons a division of Seven Hills Women's Health Centers at the following practice location:

Cincinnati Breast Surgeons
Drs. Dianne Runk, Karen Columbus,
Lydia Hernandez and Elizabeth Hartman Kuo
4850 Red Bank Expressway, 3rd Floor
Cincinnati, Ohio 45227
Fax No. (513) 221-1320
Phone No. (513) 221-2544

I understand the information to be released may include information regarding the following conditions: sexually transmitted diseases, HIV/AIDS testing and status, drug or alcohol abuse and psychiatric conditions.

_____ Release medical records for date(s) of service _____/_____/_____ to _____/_____/_____

_____ Release these specific documents: **Other:** _____

☐ Surgical Op Note w/ Pathology ☐ Mammography Screening / Diagnostic
☐ Office Procedure w/Pathology ☐ Diagnostic Ultrasound ☐ Laboratory Results

_____ Release entire medical record

Purpose or reason for the use and/or disclosure of the information requested: _____
_____

Expiration Date of Authorization: The authorization will automatically expire one (1) year from the date of signature. We will not honor requests for disclosure after expiration without an updated authorization form. You may renew or alter this authorization form at any time.
Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Cincinnati Breast Surgeons division of Seven Hills Medical Records Department, at the location list above. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request.
Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.
Effect of Refusing Authorization: If you refuse to sign this authorization, the Cincinnati Breast Surgeons division of Seven Hills will not deny you any treatment.

This form authorizes Cincinnati Breast Surgeons division of Seven Hills to use and/or disclose protected health information (PHI) in the manner described above and is voluntary. Cincinnati Breast Surgeons division of Seven Hills will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used and/or disclosed as result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

_____ _____/_____/_____ _____
Print Patient Name Date of Birth Last four digits of SS#

_____ _____/_____/_____
Signature of Patient Date of Authorization

IMPORTANT NOTE: Authorization is not valid without a signature and date by the patient. The request must be filled out completely. Refusal to sign an authorization to have records transferred to CBS division of Seven Hills will not result in an interruption of treatment.