CINCINNATI Breast Surgeons

Axia WOMEN'S HEALTH

Axia Women's Health

Authorization to Release Protected Health Information

Patient's Name: _____ DOB: _____

Patient's Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with applicable state law and the Privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. I understand that this authorization is voluntary, and I may revoke it at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, **CONFIDENTIAL HIV- RELATED INFORMATION and GENETIC TESTING** only if I place my initials on the appropriate line below.
4. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties if the recipient(s) on this form is not required to protect this information and such information is no longer protected by state and federal law.
5. If I am authorizing the release of HIV-related, alcohol or drug treatment or mental health treatment information, the recipient may be prohibited from redisclosing such information without my authorization unless permitted to do so under state and federal law.

Name of provider to release this information:

☐ **SEVEN HILLS OB-GYN ASSOCIATES, LLC**

☐ **REGIONAL WOMEN'S HEALTH GROUP, LLC** ☐**Other** _____

State the name of who to release information to, in what format and to what location:

Release To:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Format of information:

☐ US mail to address provided

☐ fax: _____

☐ other: _____

Specific Information to be released: (Check boxes below)

☐Medical record from date ____/___/___ to date ___/____/_____

☐Entire medical record including patient histories, office notes, test results, radiology studies, films, referrals, and records sent from other healthcare providers.

☐Billing Records

☐Other _____

Include by initialing:

_____ Mental Health Information

_____ HIV-Related Information

_____ Genetic Testing Information

☐ Authorization to discuss health Information. By initialing here_____ I authorize verbal discussion of my health information.

Purpose of release: (Check boxes below)

☐Request of individual ☐ Legal ☐ Insurance ☐Disability ☐ Coordination of care ☐ Transfer of care ☐Other: _____

Date or Event that Authorization expires: ___/____/___ *Authorization is good for one year unless otherwise indicated.*

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

If not the patient, name of person signing form and relationship to the patient:

Name: _____ Relationship: _____

There may be a charge for copying medical records. Please contact the office you are requesting records from for details.