The Bellevue Hospital

AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT INFORMATION

Patient Name: _____ Medical Record/Jacket #: _____

Date of Birth: _____ Telephone Number for Contact: _____

Mode of release: Mail _____ Pick Up _____ Courier_____ Pick Up Date:_____

I hereby authorize the use or disclosure of personal health information about me as described below:

1. Describe fully the information that is the subject of this authorization and which will be used or discussed as set forth below:

   _____

   _____

   Release this Information to:

   _____

   _____

   For hospital/facility use only
   Record components authorized for use or disclosure:

   ¡ Discharge Summary ¡ Entire Medical Record ¡ Operative Report ¡ X-ray
   ¡ Laboratory ¡ PT/OT/Speech ¡ Cardiopulmonary
   ¡ Other_____

2. The purpose of the authorized use or disclosure of the information described above is as follows:

   At the request of the patient _____

   Other (describe)_____

3. If you are the representative of a patient, describe the scope of your authority to act on the patient's behalf:

   _____

   _____

4. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. As described in the Notice of Privacy Practices of The Bellevue Hospital, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by The Bellevue Hospital in reliance on this authorization, by sending a written revocation to the Privacy Officer of The Bellevue Hospital, 811 Northwest Street, P.O. box 8004, Bellevue, OH 44811-8004.

6. This authorization will expire: (Check as applicable)

   ¨ At the end of research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository.

   ¨ Other (Insert applicable date or specific event)_____.

7. I understand that I am not required to sign this authorization form and that The Bellevue Hospital will not condition the provision of treatment or payment to me on the signing of this authorization, except that The Bellevue Hospital may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. The Bellevue Hospital may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

8. As the patient or legal guardian for the above identified patient, I understand that radiograph films are the property of The Bellevue Hospital, Department of Radiology and that they are part of the patient's permanent medical record and that they are the only record of the completed procedures. I understand that these records are for temporary use and must be returned with 30 days of receipt. If radiograph films are loaned to a health care provider noted above, they become responsible for returning the films. In all other cases, the patient/guardian is responsible for the return of radiograph films to The Bellevue Hospital.

_____ _____

Name of personal representative, if applicable Relationship of personal representative

_____ _____

Signature of patient (or patient's representative) Date

Authorization Expiration Date_____

_____ _____

Signature of The Bellevue Hospital representative Date