Permission to Use and Disclose Health Information for Treatment, Payment and Operations

This form provides the permission needed to use and share your healthcare information in Ohio for medical care, payment for medical care and general operations of your healthcare providers and payers. This permission allows your health care provider to share information to assist in your care, and to provide information to your insurance company or other payer to obtain payment for care. **Your information may also be disclosed when required by law.** Read more about these required disclosures in our *Notice of Privacy Practices*. By signing this form, you are not giving your informed consent for medical treatment.

The laws listed below may also apply to the release of your information. These definitions apply to the Permission Form.

Mental health
Stricter confidentiality rules protect your information if laws related to mental health cover any part of your records. See Ohio Revised Code (ORC) Section 5122.31. These laws prohibit anyone who receives your information from making any further disclosures without your specific written permission. A general permission for release of such information is not sufficient for this purpose. Mental health information released with your permission does not include psychotherapy notes. Also, state law may allow your provider to refuse to disclose mental health records to you if the provider thinks that releasing the information is not in your best interest.

HIV/AIDS information
Stricter confidentiality rules protect your information if laws related to HIV/AIDS cover any part of your records. See Ohio Revised Code (ORC) Section 3701.243. A general permission for release of such information is not sufficient for this purpose.

Drug and alcohol treatment records
Stricter confidentiality rules protect your information if drug and alcohol treatment laws (42 CFR Part 2) cover any part of your records. Federal law prohibits anyone who receives your information from making any further disclosures without your specific written permission. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law prohibits use of this information to criminally investigate or prosecute anyone having alcohol or drug abuse treatment records.

Medicaid and public assistance programs
If Ohio Medicaid or public assistance programs cover any part of your records, the Ohio Department of Job and Family Services (ODJFS) or a county equivalent may only release your records if you complete this form and meet all applicable conditions listed therein. These entities may only release your Ohio Medicaid (Chapter 5111 of the ORC) or public assistance information (found in Chapters 5101 and 5115) if **both** of the following apply:

A. The release of information is for purposes directly connected to administering the Medicaid and/or public assistance programs as defined in either federal or state law, whichever is directly applicable;
B. The information is released to persons or government entities that are subject to the standards of confidentiality and safeguarding of information substantially comparable to those established for the public assistance and/or Medicaid programs.

If this information is to be released for an insurance claim or tort action (lawsuit), Ohio law grants ODJFS rights of recovery against the liability of a third party for the cost of medical services paid by or billed to the agency. (See ORC Section 5101.58 and Ohio Administrative Code (OAC) Rule 5101:3-1-08.)

When you or someone on your behalf requests a financial statement (a claim) from a Medicaid provider for services paid by or to be billed to ODJFS, the provider must immediately notify the agency when it receives your request (OAC 5010:3-1-08(L)). In addition, the provider must forward a copy of the request to the ODJFS Bureau of Plan Operations' Benefit and Recovery Section. The provider must also stamp or type the following on each page of the financial statement: "Subject to right of recovery pursuant to Section 5101.58 of the Ohio Revised Code. Failure to comply may result in personal liability."

Workers Compensation
If release of information is for use in administering an Ohio workers' compensation claim, it is limited to medical, psychological and/or psychiatric data (excluding psychotherapy notes) causally or historically related to physical or mental injuries pertaining to that claim.

Permission to Use and Disclose Health Information
Treatment, Payment and Operations

[Insert name & Address of Provider or health plan/insurer]

Name:_____ Date of birth (mm/dd/yyyy):_____

Address:_____

Telephone numbers: (home)_____(work)_____(cell)_____

Email address: _____

Workers' compensation claim number, if applicable:_____

Social Security number (last four digits) _____Other identifier:_____

General Medical Use or Release

I give permission to [insert provider name or insurer/health plan] to use or release relevant personal health information, whether created by [insert provider name or insurer/health plan] or obtained from others, to any healthcare provider, facility, insurer or health plan so that I may receive treatment, pay for treatment or allow [insert provider or insurer/health plan] to conduct business necessary to treat or provide me with health care services. The person or entity will use or disclose only the minimum amount of information necessary. For treatment purposes, I understand that the minimum amount of information necessary may include all of my information.

This permission includes records relating to (write your initials next to the records to be included and strike through lines that do not apply):

__ Diagnoses and/or treatment for alcohol and/or drug abuse or dependency;
__ AIDS/AIDS-related complex (ARC) or HIV status diagnoses and/or treatment;
__ Mental health records.

If this is a workers' compensation claim, I give permission for information relevant to my claim, either causally or historically, to be released to the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC) and the following individuals or entities who are parties to my claim: the employer of record and/or any authorized representative(s), the employer of record's managed care organization (MCO) or qualified health plan (QHP), and my authorized representative(s). This permission to release information in connection with my workers' compensation claim will remain in effect for as long as my claim remains open under Ohio law.

I request the following restrictions on the general release of my health information. I understand that my healthcare provider must agree with these restrictions:

_____
_____
_____

Signature

I have a right to inspect or copy my protected health information. You may charge me a reasonable fee for copies of my information. See instructions for the charges that apply.

This permission continues unless I revoke it. If this permission applies to mental health records covered by ORC Section 5122.31, this permission expires 180 days from the date below unless I specify an earlier or longer date or a specific condition or event: _____

Patient:_____ Date:_____

OR:
Personal/legal representative: I, (*please print your* name) _____, represent that I am the (*circle one):* legal healthcare agent/guardian/surrogate/parent of the patient named above.

Signature:_____ Date:_____

Permission to Release Health Information

This form combines all permissions needed to disclose your healthcare information in Ohio for specific reasons, other than for treatment, payment or operations. For example, this permission is necessary to allow access to your healthcare information in connection with legal medical claims, lawsuits, or other matters. **Your information may also be disclosed when required by law.**

Notice of medical record copying charges
Entities that charge individuals for copies of protected health information should insert fees and payment policy here.

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Stricter confidentiality rules protect your information if laws related to mental health cover any part of your records. See Ohio Revised Code (ORC) Section 5122.31. These laws prohibit anyone who receives your information from making any further disclosures without your specific written permission. A general permission for release of such information is not sufficient for this purpose. Mental health information released with your permission does not include psychotherapy notes. Also, state law may allow your provider to refuse to disclose mental health records to you if the provider thinks that releasing the information is not in your best interest.

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Medicaid and public assistance programs
If Ohio Medicaid or public assistance programs cover any part of your records, the Ohio Department of Job and Family Services (ODJFS) or a county equivalent may only release your records if you complete this form and meet all applicable conditions listed therein. These entities may only release your Ohio Medicaid (Chapter 5111 of the ORC) or public assistance information (found in Chapters 5101 and 5115) if **both** of the following apply:

A. The release of information is for purposes directly connected to administering the Medicaid and/or public assistance programs as defined in either federal or state law, whichever is directly applicable;
B. The information is released to persons or government entities that are subject to the standards of confidentiality and safeguarding of information substantially comparable to those established for the public assistance and/or Medicaid programs.

If this information is to be released for an insurance claim or tort action (lawsuit), Ohio law grants ODJFS rights of recovery against the liability of a third party for the cost of medical services paid by or billed to the agency. (See ORC Section 5101.58 and Ohio Administrative Code (OAC) Rule 5101:3-1-08.)

When you or someone on your behalf requests a financial statement (a claim) from a Medicaid provider for services paid by or to be billed to ODJFS, the provider must immediately notify the agency when it receives your request (OAC 5010:3-1-08(L)). In addition, the provider must forward a copy of the request to the ODJFS Bureau of Plan Operations' Benefit and Recovery Section. The provider must also stamp or type the following on each page of the financial statement: "Subject to right of recovery pursuant to Section 5101.58 of the Ohio Revised Code. Failure to comply may result in personal liability."

Workers' Compensation
If release of this information is for use in administering an Ohio workers' compensation claim, it is limited to medical, psychological and/or psychiatric data (excluding psychotherapy notes) causally or historically related to physical or mental injuries pertaining to that claim.

Permission to Release Health Information
For purposes other than treatment, payment or healthcare operations

[Insert name & address of Provider or Health Plan/Insurer]

Name:_____ Date of birth (mm/dd/yyyy):_____

Address:_____

Telephone numbers: (home)_____(work)_____(cell)_____

Email address: _____

Workers' compensation claim number, if applicable:_____

Social Security number (last four digits) _____Other identifier:_____

I authorize [insert provider name or insurer/health plan] to disclose (write your initials next to the records to be included and strike through lines that do not apply):

All records (whether originally created or obtained from others) ___

OR (choose from below)

__ Hospital/Emergency department records
___ Physician/Clinic records
__ Skilled nursing facility/long term care records
__ Dental records
___ Physical/Occupational/Speech Therapy records
___ Treatment facility records
___Other: _____

This permission includes records relating to (check if applicable):
__ Diagnoses and/or treatment for alcohol and/or drug abuse or dependency;
__ AIDS/AIDS-related complex (ARC) or HIV status diagnoses and/or treatment;
__ Mental health records.

Send this information by (circle one) U.S. mail or electronically to:

_____ _____
Name Email

_____
Address

_____
City, State, ZIP code

_____
Telephone Fax

If this is a workers' compensation claim, information will be released to the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC) and the following individuals or entities previously identified who are parties to my claim: the employer of record and/or any authorized representative(s), the employer of record's managed care organization (MCO) or qualified health plan (QHP), and my authorized representative(s).

Purpose of disclosure:
__ At my request
__ Workers' compensation; for use in administering my Ohio workers' compensation claim identified above
__ Other – Describe why you are disclosing information:_____

By signing below, I understand that:

I have the right to revoke this permission at any time by giving written notice to (insert name and address). This revocation must be in writing except in the case of drug and alcohol treatment records

[insert provider name] will honor my revocation after [insert provider name] receives it, but I understand that my revocation will have no impact on uses or disclosures made while this permission was in effect.

This permission will remain in effect for one year or until I revoke it, whichever comes first. If this permission applies to mental health records covered by ORC Section 5122.31, then this permission expires 180 days from the date below or an earlier or longer date or a specific condition or event that I specify: _____

Except as noted in the instructions, any information used or disclosed by this specific permission may be re-disclosed by the person or entity receiving the information and may no longer be protected by federal or state law.

I have a right to inspect or copy my protected health information. You may charge me a reasonable fee for copies of my information. See instructions for the charges that apply.

If by law you cannot send the protected health information to the entity listed above, I will initial the following space to have you send a copy of the information directly to me:_____.

I am not required to sign this permission. If I refuse to sign this form, it will not affect my treatment, payment for treatment or eligibility for healthcare benefits to which I may be entitled. However, if I request a release of information, you cannot release it unless I sign this form.

I have a right to receive a copy of this signed form.

Signature

Patient:_____ Date:_____

OR:
Personal/legal representative: I, *(please print your name*) _____, represent that I am the (*circle one):* legal healthcare agent/guardian/surrogate/parent of the patient named above.

Signature:_____ Date:_____