NORTHERN OHIO MEDICAL SPECIALISTS
NOMS HEALTHCARE

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, [name of patient] _____ DOB: _____ authorize

[provider name] _____

to use and/or disclose my health information as identified below to:

Recipient: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

The purpose of this disclosure is: ☐ at the request of the individual ☐ other: _____

The dates of patient care covered by this authorization are: _____

Release the Following Information:

☐Entire Medical Record	☐Itemized Billing Statements	☐All Hospital Records
☐Urgent Care Records	☐Cardiology Report	☐Radiology/Imaging Reports
☐Lab Reports	☐Progress Notes	☐Emergency Records
☐Pathology Reports	☐Operative Report	

☐Other Records as Specified _____

Release of Highly Confidential Information:

☐*HIV/AIDS health information and/or records ☐*Genetic testing information and/or records

☐*Mental health information and/or records

☐*Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of How much and what kind of information is to be disclosed

☐ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- The person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly for doing so.
- I may revoke this authorization at any time by giving written notice to Privacy Officer, Northern Ohio Medical Specialist, 2500 W. Strub Rd., Sandusky,Oh 44870. Unless revoked earlier, this authorization will expire 180 days from the date of signing

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative Individual

Revised 6/2011