THE SPINE + PAIN INSTITUTE

Medical Record Number: _____

Account Number or Date(s) of Service: _____

ACCESS & AUTHORIZATION FOR RELEASE OF INFORMATION

Please Print:

Patient Name: _____ _____ _____
(Last) (First) (Middle Initial)

DOB: _____ Social Security Number: _____

Address: _____ _____
(Street) (City/State/Zip Code)

Phone Number: _____

Responsible Party (if other than patient): ☐ Patient ☐ Guardian ☐ Power of Attorney ☐ Executor of Estate
If responsible party is not the patient, a copy of legal documents MUST accompany the authorization when presented. The only exception is that of a parent of a minor child under 18 years of age.

I, the undersigned, hereby authorize (check all that apply): ☐ Akron General Medical Center, ☐ Edwin Shaw Rehabilitation Institute, ☐ Lodi Community Hospital to use or disclose my personal health information as described below to:

Name of Recipient: _____ Phone Number: _____

Address: _____ _____
(Street) (City/State/Zip Code)

Dates of Service to Disclose: _____

Purpose of Disclosure: _____

Information may be released (check all that apply): ☐ Written ☐ Electronic/CD

SPECIFIC INFORMATION REQUESTED:

☐ ADMISSION FORM	☐ EMERGENCY RECORD*	☐ OTHERS: _____
☐ PHYSICIAN ORDERS	☐ PROGRESS NOTES	_____
☐ PATHOLOGY REPORTS*	☐ OPERATIVE / PROCEDURE REPORTS*	_____
☐ RADIOLOGY REPORTS*	☐ LABORATORY REPORTS*	_____
☐ CONSULTATION RECORDS*	☐ ECHOCARDIOGRAM/STRESS TEST*	_____
☐ DISCHARGE SUMMARY*	☐ HISTORY AND PHYSICAL REPORT*	_____
☐ OBSTETRICAL RECORDS*	☐ MEDICATION RECORDS	☐ COMPLETE CHART
☐ NEUROLOGY REPORTS*	☐ ITEMIZED BILLING SUMMARY	☐ PERTINENT SUMMARY (includes (*) reports only)

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol and/or drug dependence/abuse**. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in 60 (sixty) days.

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.

I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility for those charges.

Authorizing Signature: _____ Date: _____

This form is HIPAA Compliant.

**Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

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DATE: _____

PART OR ALL OF REQUEST FOR RELEASE / ACCESS DENIED

- ☐ The authorization/access request was not signed by the patient.
- ☐ The authorization/access request is dated greater than 60 days upon receipt of.
- ☐ The authorization/access request form is signed by the patient's representative and the representative has not provided information on the source of his/her authority to act for the patient consistent with our Verification Policy.
- ☐ Part or all of the authorization/access request relates to a record that is not maintained by our facility.
- ☐ The authorization/access request does not contain enough patient information to locate patient. Please provide the following information: _____
- ☐ Part or all of the authorization/access request relates to information that is not a part of the designated record set.
- ☐ Part or all of the authorization/access request relates to psychotherapy notes.
- ☐ Part or all of the authorization/access request relates to information that has been compiled in anticipation of or for use in civil, criminal, or administrative proceeding.
- ☐ Part or all of the authorization/access request relates to information that is not accessible pursuant to the Clinical Laboratory Improvements Act.
- ☐ Part or all of the authorization/access request relates to information obtained by us in the course of research still in progress that includes treatment of the patient and the patient agreed to the denial of release/access when consenting to participate in the research.
- ☐ A Licensed Health Care Professional has ordered that part or all of the information not be provided to the patient or the patient's representative.
- ☐ Part or all of the requested for release/access relates to information that was obtained by us from a non-health care provider under a promise of confidentiality and access would likely reveal the source of the information.

STATEMENT OF RIGHTS WHEN ACCESS IS DENIED

Whenever your request for access to your health information is denied by AGMC in whole or part, you have the right to file a complaint regarding this denial to us by submitting the complaint at any time in writing to the ***Director of Health Information Management, 400 Wabash Ave., Akron, Ohio 44307.*** You also have the right to file a written complaint within 180 days of this notice to the Secretary of the U.S. Department of Health and Human Services in Washington D.C.

When a licensed medical care professional has determined that you should not be given access to some or all of the information you request, you have the right to have this denial reviewed. If you request such a review, we will forward your request for access to a licensed health care professional, of our choosing, who was not involved in the original denial decision. This reviewing official will determine whether to approve or deny your access request. We will comply with the decision of the reviewing official and will provide you notice of the decision. If you wish a review of your denial for access, so indicate by checking the box below and returning this form to the Director of Medical Records at the above address.

We are only required to provide for a review of your access denial if the request was denied for the following reason as indicated on the Access Approval/Denial portion of this form:

- ☐ The requested records are not available to you by order of your health care provider who has stated that the records may not be accessed by you.
- ☐ I would like the denial of my request for access reviewed by another licensed health care professional.

Name: _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

Note that no review request will be processed unless you or your legal representative has signed this form.
Return this form within 30 days of receipt of this notice as listed above.