ROICOR

THE UNIVERSITY HOSPITAL

UMC-218, Rev. 11/97

MEDICAL RECORD SERVICES, 234 GOODMAN STREET, CINCINNATI, OHIO 45267-0738

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Last Name	First	Middle	Maiden
Address	**City**	**State**	**Zip**
Date of Birth	**Social Security Number**		**Phone Number**

COPIES SENT FROM/TO

	FROM	TO
Agency/Hospital		
Name & Title of Person		
Street Address		
City, State & Zip		

INFORMATION NEEDED

	DATES
❑ Inpatient	
❑ Same Day Surgery	
❑ Outpatient Clinics	
❑ Emergency Department	

Pertinent summary documents (*) from the above visits will be sent, unless specific reports are indicated below:

- ❑ Face Sheet*
- ❑ History & Physical
- ❑ Discharge Summary*
- ❑ Operative Reports*
- ❑ Pathology Reports*
- ❑ Consultation Reports*
- ❑ Lab Reports*
- ❑ X-Ray Reports*
- ❑ Test Reports*
- ❑ Therapy Records
- ❑ Emergency Treatment
- ❑ Other _____

REASON NEEDED

Please specify the reason for your request:

- ❑ Medical Care
- ❑ Disability
- ❑ Insurance
- ❑ Legal Reasons
- ❑ Other _____

AUTHORIZATION AND EXPIRATION

This consent will expire in sixty (60) days after the date below, or sooner by my choice in which case this consent will expire on: _____.

I hereby authorize ❑ University of Cincinnati Hospital or ❑ _____ to release the medical information stated above for the reason and time specified.

I give my permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and/or test for antibodies to the AIDS virus (HIV).

_____ _____ _____

Patient/Guardian* Signature | Date | Witness Signature

*Reason patient is unable to sign _____

_____

(Provide guardianship, executor of estate, power of attorney papers if required.)