AUTHORIZATION TO ALLOW RELEASE OF PATIENT INFORMATION

Patient Name		Maiden Name
Last 4 digits of Social Security No.	Date of Birth	Phone Number

1. **Provider Making the Use or Disclosure:** I authorize ____ (referred to as "Health Care Provider") to release my/the patient's individually identifiable health information as described below.

2. **Recipient of the Information:** I authorize the Health Care Provider to release the information described in this authorization to **The Center for Closing the Health Gap in Greater Cincinnati** located at [3120 Burnet Avenue, Suite 201, Cincinnati, Ohio 45229].

3. **Type of Information to be Released:** I authorize my Health Care Provider to notify The Center for Closing the Health Gap in Greater Cincinnati that I was seen as a patient at my Health Care Provider's facility, as a follow-up to my participation in the Center's Health Expo.
Date Seen by Provider:________________________ **Provider Signature**:___________________________________

4. **Your Refusal to Sign this Authorization:** The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization, the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

5. **Purpose for the Use or Disclosure:** The purpose for the disclosure is at the patient's request. Patient requests that we follow through with follow-up health screenings.

6. **Re-disclosure:** I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

7. **Revocation:** I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

8. **Expiration:** This Authorization will expire one year after the date below.

____ ___________________________

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

Printed name of patient's representative, if applicable:____
Relationship to patient:
☐ Parent ☐ *Legal Guardian ☐ *Other:____
*Legal documentation of Representative's authority must accompany this Authorization.

Please mail or fax back to The Center for Closing the Health Gap:
Fax: 513-585-9874
Mail: 3120 Burnet Avenue, Suite 201
Cincinnati, Ohio 45229