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How to Complete Your Ohio HIPAA Authorization

Authorization for Release of Protected Health Information (45 C.F.R. 164.508)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers can talk to about you. This authorization lets the people you name receive your health information so they can help you.

1. **Who and what (Page 1)**
   Name the people who may receive your information and choose what may be released.
2. **Sign before a notary (Page 2)**
   Hospitals and insurers are more likely to accept a notarized authorization. Bring a current, government-issued photo ID.

After It's Signed

- Give copies to the people you named and to your doctors and health plans.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Attorneys licensed in California, Nevada, and other states.

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HIPAA AUTHORIZATION

Authorization for Release of Protected Health Information (45 C.F.R. 164.508)

1. PATIENT

Full legal name

Date of birth

Address

Telephone

2. WHO MAY RELEASE INFORMATION. Every physician, hospital, clinic, laboratory, pharmacy, therapist, health plan, insurer, and other covered entity that has provided treatment, services, or payment to me.

3. WHO MAY RECEIVE INFORMATION

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

4. INFORMATION TO BE RELEASED (check one)

All of my health information.

Only the following:

Unless I initial below, this authorization does not include psychotherapy notes or these specially protected records. I separately authorize release of (initial each):

☐ Mental health records (other than psychotherapy notes)

☐ HIV test results and related information

☐ Substance use disorder treatment records

☐ Genetic testing information

Patient's initials: _____

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5. PURPOSE. At my request, to allow the persons named to discuss my care with my providers and assist with my health care and insurance matters.

6. EXPIRATION (check one)

Two years after my death.

On the following date or event:

Date or event

7. MY RIGHTS. I may revoke this authorization in writing at any time, except for action already taken in reliance on it. My treatment, payment, enrollment, or eligibility will not be conditioned on signing it. Information disclosed may be redisclosed and may no longer be protected by federal privacy rules. A copy is as valid as the original. My attorney in fact under any health care power of attorney is to be treated as my personal representative.

Date

X

Signature of patient (or personal representative)

Printed name

NOTARY ACKNOWLEDGMENT

STATE OF OHIO)
) ss.
**COUNTY OF) **

This document was acknowledged before me on

(date)

by (name of signer)

X

Notary Public

(Notary seal)

Notary's printed name

My commission expires

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