Bethesda North Employee Health
Fax (513) 865-1161
bnemployeehealth@trihealth.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, **[Print Name of Patient]** hereby authorize the Employee Health department of TriHealth, Inc., (referred to as "Health Care Provider") to use and/or disclose my individually identifiable health information as described below:

TO: _____
Person/Organization

Send requested records by (select one): ☐ Email:_____
☐ Fax: _____
☐ U.S. Mail:_____
Street Address, City, State, ZIP

The following individually identifiable health information may be used and/or disclosed (check all that apply):

____ History and Physical Records	____ Immunization (Shot) Records	____ Outpatient Clinic Notes
____ Reports of Tests and X-Rays	____ Consultation Reports	____ Outpatient Records
____ Emergency Room Records	____ Inpatient Records	____ Other:_____

____ **Dates of Treatment to be released:**_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.

Reason or Purpose for the use and/or disclosure of the information:

_____

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.

Re-Disclosure: I understand that 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 alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure 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 CFR part 2.

Expiration: This Authorization will expire sixty (60) days after the date below, or sooner by choice, in which case this Authorization will expire on _____ (insert date on the foregoing line; Note: you may not indicate that there is no expiration, for example the words "does not expire" or "no expiration" or "none" are not acceptable)

Revocation: I understand that I may revoke this Authorization at any time by notifying **TriHealth** in writing by sending a letter to the Medical Records Manager, Good Samaritan Hospital, 375 Dixmyth Avenue, Cincinnati, Ohio 45220. If this Authorization allows the release of billing records and I wish to revoke the authorization to use and/or disclose my billing records, I understand that I may revoke by sending a letter to the Director, Patient Accounting, TriHealth, Inc., 619 Oak Street, Cincinnati, Ohio 45206. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.

_____ _____ (____)_____
Signature of Patient Date Phone Number

*Patient's Date of Birth: _____ / _____ / _____ *Patient's Social Security Number:_____

The above information is required in order to verify the identity of the patient and locate the patient's protected health information.