The Christ Hospital Health Network
2139 Auburn Ave.
Cincinnati, OH 45219
513.585.2000

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FORMS

ALL PATIENTS/PATIENT REPRESENTATIVES MUST COMPLETE AN AUTHORIZATION FORM.

Records will not be disclosed without an authorization form signed by the patient/ patient representative.

❖ PATIENT INFORMATION

Identifies the patient to ensure the correct patient's records are being disclosed.

- Include the patient's name and DOB or the patient's name and SSN.
- Also must include the patient's mailing address.

❖ COPIES SENT FROM/TO

Identifies *from* where the records are being released and *to* whom the records are to be sent.

- From: The Christ Hospital Health Network
- To: write the name and address of where the records are to be sent.

❖ PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Identifies the records you are requesting copies of.

- Check the box that describes your hospital encounter. On the line provided, write the date(s) of treatment.
- If you are unsure of the date(s) – an estimated date range can be provided or you can leave the space blank. We can contact the patient to confirm the dates if needed.
  2nd side of the authorization form…
- Check the box that describes the type of documents you are requesting from the record.

❖ REASON NEEDED

- Indicates the purpose of the request.

Please read the statements. The boxes do not need to be checked.

❖ EXPIRATION

- Our authorization forms expire 60 days from the date of the signature, unless otherwise noted. A preferred expiration date can be inserted on the line provided.

The final statement on the authorization form explains to the patients/personal representative, the release of their protected health information could include treatment, diagnosis or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS) and/ or test for antibodies to the AIDS virus (HIV).
The box does not need to be checked…

❖ SIGNATURE AND DATE OF PATIENT/LEGAL REPRESENTATIVE

- **ALL FORMS MUST BE SIGNED AND DATED BY THE PATIENT/PATIENT REPRESENTATIVE!**