

**ROI Authorization**

MEDICAL RECORDS DEPARTMENT

TELEPHONE NUMBER: (513) 298-7750

FAX NUMBER: (513) 298-7765

**AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION**

TO BE USED: 1) When patient or patient's legal representative requests use or disclosure of PHI; 2) for requests by or to an entity unless exceptions apply; 3) for use and disclosure of PHI for research (when patient has not signed a research informed consent that includes authorization or researcher has not received a waiver by the I.R.B. or privacy board); and 4) when no other exceptions apply.

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**Protected Health Information ("PHI")** under HIPAA is defined as information that is received from, or created or received on behalf of the Health Alliance and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; 3) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

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**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Maiden: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_

**COPIES SENT FROM/TO**

<b>Agency/Hospital</b>	<b>From:</b>	<b>To:</b>
Name & Title of Person:	<u>West Chester Medical Center</u>	_____
Street Address:	<u>7700 University Drive</u>	<u>900 Memorial Drive</u>
City, State & Zip	<u>West Chester, OH 45069</u>	<u>Lebanon OH 45036</u>



