



- Bethesda Care Arrow Springs**
Phone: 513-282-7075
Fax: 513-282-7076
- Bethesda Care Butler County**
Phone: 513-874-3990
Fax: 513-860-5071
- Bethesda Care Eastgate**
Phone: 513-752-3695
Fax: 513-752-3039
- Good Samaritan**
Phone: 513-862-2875
Fax: 513-862-2860
- Bethesda Care Norwood**
Phone: 513-731-3399
Fax: 513-731-2882
- Bethesda Care Queensgate**
Phone: 513-241-4135
Fax: 513-241-6510
- Bethesda Care Sharonville**
Phone: 513-563-1505
Fax: 513-769-4776

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (patient name), hereby authorize Bethesda Healthcare, Inc. to use and/or disclose my individually identifiable health information maintained by the Center/Service marked above as described below:

The following individually identifiable health information may be used and/or disclosed. **Check (✓) all that apply:**

- All Records
- History and Physical Exam Forms
- Results of Physical Examination
- Results of Tests (including diagnostic tests)
- Immunization Record
- Physical Therapy Notes
- Billing Records, including Itemized Statements
- Injury Care
- Results of OSHA Respirator Questionnaire
- Other: _____

Dates of Treatment/Medical Examination or Service to be released. **Check (✓) only one box.**

- All treatment/examination dates
- Other (please specify): _____

I authorize the following person(s) or organization to receive the information:

Name/Organization: _____
 Street Address: _____
 City, State, and Zip Code: _____

I authorize the release of any information contained in the records checked above including 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 Staff may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization, the Center will not withhold treatment from you.
- If the purpose of performing the medical examination or service is solely to create information for disclosure to a third party (such as your employer or prospective employer), the Staff has the right to and will condition the performance of a medical examination or service on whether or not you sign this Authorization.

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 without my authorization 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Expiration: This Authorization will expire: Once purpose stated above is served _____ (date) _____ (event)

Revocation: I understand that I may revoke this Authorization at any time by notifying Bethesda Healthcare, Inc. in writing by sending a letter to the address of 11129 Kenwood Road, Cincinnati, Ohio, 45242, addressed to the Privacy Coordinator, or completing the Revocation and Confidentiality Request. I understand that if I revoke this Authorization, it will not affect any actions that the Staff has taken before they received my revocation letter.

Signature of Patient or Patient's Representative

Date

Printed name of patient's representative, if applicable

Relationship to Patient