

**Trumbull Regional Medical Center**  
**Patient Request /Authorization to Use and/or Disclose Protected Health Information**

Medical Record # \_\_\_\_\_

I hereby authorize **Trumbull Regional Medical Center** to use and/or disclose the Protected Health Information specified below from my medical records:

**1) PATIENT NAME:** (Please Print) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street City State Zip  
 Contact Telephone Number(s): \_\_\_\_\_  
 Email: (if applicable) \_\_\_\_\_

**2) INFORMATION TO BE DISCLOSED TO:**

Person or Facility Name (Please print) \_\_\_\_\_  
 Address (Please print) City State Zip \_\_\_\_\_

Fax # _____
Phone # _____

Email: (if applicable) \_\_\_\_\_

- 3) Preferred Delivery Method -**  
 Email  
 Postal Mail to address in # 2 above  
 In Person Pick-Up

**4) Treatment Dates From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Admission History and Physical | <input type="checkbox"/> Laboratory Results                       | <input type="checkbox"/> Rehab Services (PT, OT, Speech) |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Imaging Reports (Specify CT, X-Ray, MRI) | <input type="checkbox"/> Other (be specific)             |
| <input type="checkbox"/> Consultation                   | <input type="checkbox"/> Pathology Reports                        | _____  |
| <input type="checkbox"/> Emergency                      | <input type="checkbox"/> Operative Notes                          | _____  |
| <input type="checkbox"/> EKG Reports                    |   |  |

**6) RESTRICTED RELEASE:** We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
<input type="checkbox"/> Mental/Behavioral Health Provider Documentation*		<input type="checkbox"/> Genetic Testing/Test Results*	
<input type="checkbox"/> HIV/AIDS Screening Test Results		<input type="checkbox"/> Alcohol*** and/or <input type="checkbox"/> Substance Abuse Treatment***	
<input type="checkbox"/> Confidential Communications with a Social Worker		<input type="checkbox"/> Child/Elder Abuse and Neglect	
<input type="checkbox"/> Rape/Sexual Assault Victim's Counseling		<input type="checkbox"/> Domestic Violence Victim's Counseling	
<input type="checkbox"/> Sexually Transmitted Disease			

\* This authorization is not valid for use or disclosure of psychotherapy notes

\*\* The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

\*\*\*Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Not required for records created or maintained by a general medical facility.

**IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2**



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**7) EXCLUSION REQUEST:**

I request that the following admission(s) / visit(s) be specifically excluded from this request \_\_\_\_\_ (specify dates of service)

**8) PURPOSE OF THE DISCLOSURE:**

Medical Care  Legal  Insurance  Personal  Other \_\_\_\_\_

\*fees may apply

**9) TERM:** This Authorization will remain in effect for one year or:

- Until **Trumbull Regional Medical Center** fulfills this request.
- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_
- Until the following event occurs: \_\_\_\_\_
- Other: \_\_\_\_\_

**10) REVOCATION:** I understand that I may revoke this Authorization at any time by requesting it of **Trumbull Regional Medical Center** in writing at the address listed below. The revocation will be effective immediately upon **Trumbull Regional Medical Center** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **Trumbull Regional Medical Center** reliance on this Authorization before it received my written notice of revocation.

**Attention Health Information Management**  
**Trumbull Regional Medical Center**  
 1350 East Market Street  
 Warren, OH 44482

**11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **Trumbull Regional Medical Center**.

**12) POTENTIAL FOR REDISCLOSURE:** I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **Trumbull Regional Medical Center**.

**13) ACCESS:** I understand that in certain circumstances **Trumbull Regional Medical Center** has the right to deny me access to all or portions of my Protected Health Information **Trumbull Regional Medical Center** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize **Trumbull Regional Medical Center** to use and/or disclose my health information in the manner described above.

14) \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Patient

Printed Name of Patient \_\_\_\_\_ Witness \_\_\_\_\_

For Office Use: <input type="checkbox"/> I.D Verification _____
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Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Personal Representative

Printed name of Patient Representative \_\_\_\_\_ Relationship to patient or authority to act for patient \_\_\_\_\_

**Questions about the release should be directed to the hospital HIM Director.**

For Office Use:

- Copy of this authorization provided to the patient
- Copy of this authorization provided to the personal representative

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Signature of Personnel Completing Request \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

