OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

REQUEST FOR RELEASE OF OUTSIDE RECORDS

I understand that:
This authorization is voluntary and will remain in effect until the authorization expires or I provide a written notice of revocation to OHC's Privacy Officer at 5053 Wooster Rd. Cincinnati, OH 45226. Revocations will not apply to information that has already been released.

This authorization will expire 180 days from the date signed, unless otherwise specified on the following date: _____ / _____ / _____.

Patient Information
Patient Name: _____
Current Street Address: _____
City/State/Zip: _____

Last 4 digits of Social Security Number: _____
Phone Number: (_____) _____- _____
Date of Birth: _____ / _____ / _____

I hereby authorize the release of information from following Physician/Hospital/Clinic:
Name of Person/Organization: _____
Street Address: _____
City/State/Zip: _____

Send Information to: This authorization is to release your protected health information to OHC.
Individual or Healthcare Provider Name: _____
Street Address: _____
City/State/Zip: _____
Phone Number: (_____) _____- _____
Fax Number: (_____) _____- _____ Attention: _____

Release the following information:
□ All Treatment Records
□ Laboratory □ Inpatient Records □ Outpatient Records □ Radiology □ Pathology

Specify Dates of Service you are authorizing to be released to OHC.
All Dates of Service Date Range from: _____ / _____ / _____ to _____ / _____ / _____
(month) (day) (year) (month) (day) (year)

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print Personal Representative Name (please attach applicable legal documentation) Relationship to Patient