Site ID: ______

204-OH (2020)Authorization for Release of Medical & Billing Records

Find us on the web at: https://www.ahni.com

Please note that there may be a charge for providing copies of your medical records as allowed by Federal & State Law.

MEDICAL RECORDS OF (*PATIENT INFORMATION*):

First: ______________________ Date of Birth: __________

Maiden/Middle: ______________________

Last: ______________________ Last 4 digits of SS #: ______

Address: Street Name: ______________________

City ______________________ State ______ Zip Code ______

Telephone: ______________________ Email: ______________________

Return Completed Form To Your AHN Doctor's Office At:

American Health Network of Ohio, LLC

Practice Name: ______________________

Address: ______________________

____

______________________ OR

Fax To: ______________________

Telephone: ______________________

RECORDS TO BE RELEASED FROM: American Health Network of Ohio, LLC ("AHN"): *provide AHN practice name & physician name and address*

____

RECORDS TO BE RELEASED TO: I, ______________________ request and authorize AHN to release my medical & billing records:

(Name of person or organization receiving records): ______________________

Address: ______________________
(Street Name) *(City)* *(State)* *(Zip code)*

Fax: ______________ Telephone: ______________ Email: ______________

***METHOD OF DELIVERY**: AHN will provide paper copies of the requested record. You may request an alternative delivery format, and if we are able, we will provide the records in the requested format:* ______________________

REASON FOR DISCLOSURE *(For the purpose of)*:

☐ Continuing Care	☐ Referral to a Specialist	☐ Change of Doctor/Provider	☐ Personal
☐ Insurance	☐ Workers Comp	☐ Disability Determination	☐ Legal

INFORMATION TO BE RELEASED: At my request, release the following information *(check all that apply)*:

☐ **Date(s) of service**: From ____________ to ____________ OR, ☐ Last two years ____________

☐ AHN provider notes	☐ AHN X-ray reports
☐ AHN Special Diagnostic test results	☐ AHN Chemical/Alcohol Treatment records
☐ AHN Lab reports	☐ ALL AHN Medical & Billing Records
☐ AHN Billing records	☐ Other (specify)

SPECIAL LIMITATIONS: Unless I HAVE LIMITED BELOW, I understand that the release of records also pertains to those regarding testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease.** Or, indicate **LIMITATIONS BELOW:**

1. Confine to **summary information** from records regarding treatment for following condition or injury:
   ______________________ On or about (date(s) ____________
2. Other: ______________________

**Note: AHN has contracted with a third party copy service vendor (CIOX Health) to process requests for, and produce medical records. There may be a charge for providing a copy of your records as allowed by Federal and State Law. Carefully review attached copying fee schedule*

I UNDERSTAND: (1) THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE; (2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CALLING AHN PRIVACY OFFICE AT (317) 580-6369 OR BY EMAIL AT AHN_privacy@ahni.com; HOWEVER, THE REVOCATION WILL NOT HAVE AN EFFECT ON ANY ACTIONS TAKEN PRIOR TO THE DATE MY REVOCATION IS RECEIVED AND PROCESSED BY AHN. (3) MY HEALTH INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE AUTHORIZED RECIPIENT, AND IF THE RECIPIENT IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE INFORAMTION MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION; (4) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT, AND; (5) I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE HEALTH CARE TREATMENT AND AHN WILL NOT CONDITION TREATMENT OR PAYMENT FOR HEALTHCARE SERVICES ON WHETHER I SIGN THIS AUTHORIZATION. **Specify authorization expiration date (if not 60 days)** ______________

Patient Signature: ______________________ **Date** ______________

Patient Legal Representative: ______________ ______________ ______________ ______________
(Name) *(Relationship to patient)* *(Signature)* *(Date)*

For Office Use only:

Date Received: ______________ **Received by:** ______________

Date Released: ______________ Released by: ______________ *(File: See instructions in policy # 203)*