CITY OF CINCINNATI

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Shaded areas denote required fields):
TO: *(insert name of benefits administrator or provider who you are requesting to release information)*:

Indicate applicable City Health Plan: Blue Access: Blue Priority:

Name of individual authorizing use or disclosure:
Subscriber ID/SSN #:
Address:
Telephone #: ( ) _____ - _____ Fax #: ( ) _____ - _____ Cell Phone # ( ) _____ - _____

I authorize the use or disclosure of the above named individual's information as described below. *Check all that apply:*

ð Any and all records including mental health, HIV/AIDS (including testing, diagnosis and treatment), genetic testing and/or substance abuse records.
(*Cross out any item you do not authorize to be released*)

ð Records regarding treatment for the following condition or injury _____
_____ on or about _____

ð Records covering the period of time _____

ð Other (Please specify and include dates) _____
_____

This information may be disclosed to, and used by, the following individuals or organizations:
Name:
Address:
Name:
Address:

Please indicate the purpose(s) for this release of information. *Check all that apply:*

ð Enrollment Information ð Benefit or Coverage information ð All claims information

ð All services from a specific health care provider (List provider's name):_____

ð For the following purposes: _____
_____

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying in writing the company/individual listed above from providing the information identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions taken before my revocation was received.
- I would like this authorization to expire on (enter date): _____/_____/_____
  (If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt)
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the city or individual receiving the authorization.
- I should retain a copy of this authorization form.

Signed: _____ Date:
Print Name:_____
Signature of individual, parent on behalf of minor, or legal representative

If signed by a legal representative, relationship to individual: _____
Please provide representative documentation, i.e. Power of Attorney, Health Care Surrogate or Guardianship papers.