204-OH 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 4 digits of SS #:_____

Last:_____

Address: Street Name:_____

City_____ State_____ Zip Code_____

Telephone:_____ Email:_____

Return Completed Form To:

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"):

Practice or physician name & address: _____

RECORDS TO BE RELEASED TO: I *(insert name of Patient/patient representative)* _____ hereby request and authorize American Health Network of Ohio, LLC ("AHN") to release my medical & billing records as indicated below to (*Name of person or organization receiving records)*: _____

Address: _____ ___

(*Street Name)* (*City)* (*State)* (*Zip code)*

Fax: _____Telephone:_____Email:_____

***FORMART 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:* _____

FOR THE PURPOSE OF (*reason for disclosure***)**:

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 Medical 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: _____

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 OR EMAILING AHN COMPLIANCE OFFICE AT:(317) 580-6448 OR BY EMAIL AT Compliance@ahni.com, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE; (3) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT 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, PAYMENT, ON WHETHER I SIGN THIS AUTHORIZATION. Specify authorization expiration date (if not 60 days)

_____

Patient Signature:_____Date_____

Patient Legal preventative: _____ _____ _____ _____

(Name) (Relationship to patient) (Signature) (Date)

For Office Use only:

Date Received: _____ **Received by:** _____

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