Cefaratti Group
THE LITIGATION SUPPORT COMPANY

HIPAA COMPLIANT
MEDICAL RECORD AUTHORIZATION

45 CFR § 164.508

I, _____ *HEREBY AUTHORIZE*

(Patient name)

_____

(Hospital/Doctor name)

to release or disclose the protected health information identified below from my medical records:

Patient Date of Birth: *S.S.N.:*

☐ **ENTIRE MEDICAL RECORD**

☐ **OTHER** (as specifically identified):

I understand that the information to be disclosed may include records relating to alcohol or drug abuse, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), sexually transmitted disease, billing records. It may also include information about behavioral or mental health services to the individuals or organizations listed below.

I authorize you to release the information to: **CEFARATTI GROUP, INC., 4608 St. Clair Avenue, Cleveland, Ohio 44103**

The purpose and need for such disclosure: **FOR PRETRIAL DISCOVERY**

Case Caption:

I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to: Hospital/Doctor listed above. I understand that a cancellation will not apply to information that has already been released under this authorization. I also understand that information disclosed pursuant to this authorization may no longer be subject to state or federal privacy regulations and laws.

I understand that information disclosed pursuant to this authorization may be re-disclosed to any other counsel representing any plaintiff or defendant in the lawsuit, which I am involved and is the purpose of this authorization.

I understand that this authorization will be valid from the date signed for a period of one year. A photocopy of this document shall be considered valid as if the original were offered. This authorization is only valid if submitted by Cefaratti Group, Inc.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524.

_____ _____

Date signed Signature

Relationship to Patient: Self _____ Other_____

Cefaratti Record Retrieval & Process Service
4608 St. Clair Avenue, Cleveland, Ohio 44103
216.696.1161 • (fax) 216.912.0001 • 1.800.694.4787
www.cefgroup.com

Print Form

Cefaratti Group
THE LITIGATION SUPPORT COMPANY
From File...To Trial

4608 St. Clair Avenue
Cleveland, Ohio 44103

T + 1 216 696 1161
F + 1 216 912 0001

www.cefgroup.com

AUTHORIZATION TO RELEASE CLAIMS INFORMATION SUBMITTED TO A BANKRUPTCY TRUST CREATED UNDER 11 USC § 524g

CLAIMANT'S NAME: test_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER: _____

For the purpose of review and evaluation in connection with a legal claim, I hereby expressly authorize the _____ [hereinafter "Trust"] to release to Cefaratti Group any and all information and supporting documentation submitted by the Claimant, or on his behalf, asserting a claim for compensation against the Trust as a result of the Claimant's exposure to asbestos-containing product(s) manufactured, sold or distributed by the bankrupt debtor(s) represented by the Trust. This request shall include any and all Applications, any and all amendments to Applications, all supporting documentation to the Application(s), and all other claims information including all supporting documentation All documents and claim information alleging or referring to the Claimant's exposure to any asbestos or asbestos-containing product shall be included in the production.

The undersigned understands that the requested information may also include documentation of the Claimant's medical treatment for physical and mental illness, which the undersigned expressly authorizes the Trust to release to the requesting party as designated below.

The undersigned has been advised of and is fully aware of any and all rights set forth under federal bankruptcy law that may control the handling and release of privileged and confidential information relating to claimant and the above identified Trust. In that connection, the undersigned releases the Trust from any and all obligations pertaining to the release of information requested herein imposed upon it by the bankruptcy court pursuant to whose jurisdiction the Trust was formed, and from any obligations imposed by any plan of reorganization or otherwise, whether by Trust policy, procedure, or at law. Claimant waives and releases the Trust from any and all claims, causes of action, lawsuits, or liability of any kind based upon or arising out of the Trust's providing these materials.

The undersigned has been advised of and is fully aware of any and all rights set forth under state and federal law that may control the handling and release of privileged and confidential information , including all such rights related to medical information, and including but not limited to

Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Health Data Services, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

216/444-2640
800/223-2273 ext. 42640
Fax: 216/445-7589

Patient:_____ SS#:_____

Clinic#:_____ Date of Birth: _____ / _____ / _____

Telephone #:_____ Current Address: _____

City: hel_____ State:_____ Zip:_____

I hereby authorize the Cleveland Clinic to release the health information indicated below that is contained in my patient records to the Recipient named below. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* The release of Psychotherapy Notes requires a separate authorization.**

Name of Recipient: _____ Telephone: _____
(please print)

Street: _____

City: _____ State: _____ ZIP:_____

Reason for Disclosure:_____
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____

Please list additional Cleveland Clinic locations if needed:

	Emergency Department Reports		Pathology Reports		Cleveland Clinic Family Health Centers (list locations below):
	Discharge Summary		Laboratory Reports		,
	History & Physical		Radiology Reports		,
	EKGs		Operative Reports		,
	Physical/Occupational Therapy Reports		Other Specify):_____		,

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.** I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

_____ / _____ _____ / _____ / _____
*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____
Relationship if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*

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www.cefgroup.com

AUTHORIZATION TO RELEASE
EMPLOYMENT, PAYROLL, AND PERSONNEL RECORDS

NAME: _____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER: _____

I hereby authorize you to provide to Cefaratti Group, **4608 St. Clair Avenue, Cleveland, Ohio 44103,** a complete copy of all records pertaining to my employment, including, but not limited to all personnel, payroll, employment history, pension, retirement, incident, grievance or accident records pertaining to me.

A copy of this Authorization shall have the same force and effect as the original.

This Authorization shall remain in full force and effect for a period of one year unless specifically revoked in writing by me.

_____ **X**_____

Date Signature by Employee or Representative

_____

(Relationship if not signed by Claimant)

AUTHORIZATION FOR RELEASE OF EDUCATIONAL INFORMATION

The Family Educational Rights and Privacy Act (FERPA) protects student confidentiality by placing certain restrictions on the disclosure of information contained in a student's educational records. By signing this form, you agree that the entity indicated hereinabove may provide information from your education records as indicated below.

Name of Student: _____ DOB: _____

Educational Institution: _____

I, the undersigned, authorize the release of any and all educational records and/or any information contained therein to:

Cefaratti Group
THE LITIGATION SUPPORT COMPANY
From File...To Trial

4608 St. Clair Avenue
Cleveland, Ohio 44103
T(216)696-1161
F(216)912-0001

These records may include some or all of the following materials:

- Admission applications
- Attendance records
- Disciplinary records
- Referrals or requests for evaluation, including those for special education and related services under the Individuals with Disabilities Education Act (IDEA)
- Evaluations and assessments under IDEA
- Decisions and determinations for eligibility under IDEA
- Individual Education Program (IEP) plans , progress, assessments, reports and reviews
- Assessments of educational performance including tests and test results, observation notes and grades
- Medical records
- Psychiatric and/or psychological records, including assessments, notes and reports.
- Counseling records
- Correspondence
- Records received from schools and/or institutions

I understand and acknowledge that: (1) I have the right not to consent to the release of my education records; and (2) this consent shall remain in effect until revoked by me, in writing, and delivered to The Ohio State University, but that any such revocation shall not affect disclosures made prior to the receipt of any such written revocation.

_____ _____

Signature Date

Form **4506**

(Rev. January 2011)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)

4 Previous address shown on the last return filed if different from line 3 (See instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____	_____	_____	_____
_____	_____	_____	_____

8	**Fee.** There is a $57 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ **$57.00**
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of signature date.*

Sign Here

▶ **Signature** (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a
▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
▶ **Spouse's** signature	Date	

Form **4506-T**

(Rev. January 2011)

Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)

4 Previous address shown on the last return filed if different from line 3 (See instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Caution. *If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. . ☐

c **Record of Account,** which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

_____ _____ _____ _____

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of signature date.*

		Telephone number of taxpayer on line 1a or 2a
► **Signature** (see instructions)	Date	

Sign Here

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature**	Date

OMB No. 3095-0039 Expires 7/31/2011

QUESTIONNAIRE ABOUT MILITARY SERVICE

1. WHY WE ARE SENDING YOU THIS FORM: We are unable to locate a record with the information provided in your original inquiry **OR** the record needed to answer your inquiry was lost in the July 1973 fire that destroyed millions of records at the National Personnel Records Center. The records stored in the area which suffered the most damage in the fire were those of Army veterans discharged or deceased between November 1, 1912, and December 31, 1959, **AND** Air Force veterans discharged, deceased, or retired before January 1, 1964, whose names come alphabetically after Hubbard, James E.

The information you provide on page 2 of this form may help locate the record, if it is available; or, if the record is not available, it may enable the Center to make use of various alternate sources to reconstruct some of the basic service record data. Please note that if the *only* document you need is the Report of Separation (DD Form 214, WDAGO Form 53-55, etc.), it may be available from a former employer or from the recorder's office of the city or county where the veteran lived just after separation/discharge.

2. WHAT YOU NEED TO DO:

- ☞ Fill out page 2 of this form (NA Form 13075) as completely as possible, as well as any other form(s) you may have received with this one, such as Standard Form (SF) 180 and NA Form 13055;
- ☞ Attach copies of any papers you have that relate to the requested military service, such as military orders, award citations, and military addresses as shown on letters mailed home; and
- ☞ Send the above item(s) to the National Personnel Records Center at the address shown below or fax to (314) 801-9195. If we do not receive this information from you within 30 days, your request will be closed without further reply.

3. FEE FOR ARCHIVAL RECORDS: A fee is often required for copies of documents from an archival record. An archival record is one that was transferred to the legal custody of the National Archives and Records Administration (NARA) 62 years after the subject of the record was discharged or retired, or died in service. Archival records are open to the public. Access to archival records does not require written authorization from the veteran or next-of-kin. You will be notified if there is a charge associated with information from the record you are requesting.

4. MEDALS INFORMATION: Are you requesting military service medals only? If so, do you have a copy of the Report of Separation (DD Form 214, WDAGO Form 53-55, etc.) and other military papers that show which medals were earned? If you send such information about medals, you do not need to fill out this NA Form 13075; however, you must return page 2 (with the barcode) so that we can locate your original request. Finally, if possible, please send a list of the names and locations of all military units or "outfits" to which the veteran was assigned, including dates, while on active duty. This may help determine eligibility for "unit" awards.

Special provisions when a record is archival: Only requests from veterans for replacements of awards will be processed without a fee. All other requesters will be given the opportunity to purchase copies of available archival records in the custody of the National Archives and Records Administration (NARA). We will not verify entitlement to medals, provide specific documents, or extract awards information for anyone other than the veteran when the record is archival.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e) (3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the National Personnel Records Center may not have all of the information needed to locate the record(s) sought. The purpose of the information on this form is to assist the National Personnel Records Center in locating the correct military service record(s) or information to answer your inquiry. This form is then filed in the requested military service record as a record of disclosure. The form may be disclosed to the Department of Defense components or the Department of Homeland Security (DHS, U.S. Coast Guard), if the National Personnel Records Center transfers all or part of those records to such agency. If the service member was a member of the National Guard, the form may be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served. The form may also be disclosed when the military service member or, in the case of a deceased service member, the military service department, authorizes a specific individual or organization to have access to the military service record.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. The information requested on this form is being collected and used by the National Personnel Records Center to identify and locate military service records that could not be identified and located in response to the original inquiry. Public burden reporting for this collection of information is estimated to be five minutes per response, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS TO THE ADDRESS BELOW.

Date

Prepared by

NRPM____

NATIONAL PERSONNEL RECORDS CENTER
(Military Personnel Records)
9700 Page Avenue
St. Louis, MO 63132-5100

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/evetrecs/.

2. Personnel records and Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and STR's are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, such as a copy of a death certificate, letter from funeral home or obituary.

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified as soon as that determination is made.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Print Form

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Cleveland, Ohio 44103

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www.cefgroup.com

AUTHORIZATION TO RELEASE WORKERS' COMPENSATION RECORDS

STATE OF _____

Injured worker

Name	Date of birth	Claim number	
Address			
City	State	ZIP code	Phone number

Records requestor

Name	Business name		
	CEFARATTI RECORD RETRIEVAL		
Address			
4608 ST. CLAIR AVENUE			
City	State	ZIP code	
CLEVELAND	OH	44103`1	
Phone number	Fax number	E-mail address	
216-696-1161	216-912-0001	RECORDSINFO@CEFGROUP.COM	

Specific Information Authorized

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding **any and all** of my BWC claims.

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding the following BWC claim(s):

_____

☐ Complete claim file(s)
☐ Claim status
☐ Industrial Commission of Ohio orders
☐ Medical records
☐ Wages/payments
☐ Medical billing history
☐ Other _____

By signing below, I represent that I have the authority to sign this document, and I acknowledge the following:

- I understand the information included in my health and medical records may include sensitive information related to private health matters;
- I understand BWC does not control the use of the released information once it has been disclosed to a recipient; any disclosure of information creates the potential for an unauthorized re-disclosure by the recipient; and that BWC expressly denies any liability for any consequences arising out of such disclosure;
- I understand this authorization is only valid for one year from the date of signature;
- I further understand I have a right to revoke this authorization at any time;
- I understand I can refuse to sign this authorization, and I further acknowledge that I have executed this authorization voluntarily and by my own free will.

Signature of injured worker (or legal guardian, authorized representative, or executor, where applicable)	Date

Ohio | Bureau of Workers' Compensation

Authorization to Release Information

Injured worker

Name	Date of birth	Claim number	
Address			
City	State	ZIP code	Phone number

Records requestor

Name	Business name CEFARATTI GROUP	
Address 4608 ST. CLAIR AVENUE		
City CLEVELAND	State OHIO	ZIP code 44103
Phone number 216.696.1161	Fax number 216.912.0001	E-mail address recordsinfo@cefgroup.com

Specific Information Authorized

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding **any and all** of my BWC claims.

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding the following BWC claim(s):

_____

☐ Complete claim file(s)
☐ Claim status
☐ Industrial Commission of Ohio orders
☐ Medical records
☐ Wages/payments
☐ Medical billing history
☐ Other _____

By signing below, I represent that I have the authority to sign this document, and I acknowledge the following:

- I understand the information included in my health and medical records may include sensitive information related to private health matters;
- I understand BWC does not control the use of the released information once it has been disclosed to a recipient; any disclosure of information creates the potential for an unauthorized re-disclosure by the recipient; and that BWC expressly denies any liability for any consequences arising out of such disclosure;
- I understand this authorization is only valid for one year from the date of signature;
- I further understand I have a right to revoke this authorization at any time;
- I understand I can refuse to sign this authorization, and I further acknowledge that I have executed this authorization voluntarily and by my own free will.

Signature of injured worker (or legal guardian, authorized representative, or executor, where applicable)	Date

Print Form

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information)

Please release the following information:

- ☐ Social Security Number
- ☐ Identifying information (includes date and place of birth, parents' names)
- ☐ Monthly Social Security benefit amount
- ☐ Monthly Supplemental Security Income payment amount
- ☐ Information about benefits/payments I received from _____ to _____
- ☐ Information about my Medicare claim/coverage from _____ to _____
- (specify) _____
- ☐ Medical records
- ☐ Record(s) from my file (specify) _____
- _____
- ☐ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Death: / / Date of Birth: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $102**

(Includes the names and addresses of employers)

If you check this box, tell us why you need this information below.

Year(s) Requested: to

Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $32.00 fee.

☐ **Certified Yearly Totals of Earnings $32**

(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to

Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.

I authorize the Social Security Administration to release the earnings information to:

Name

Address State

City ZIP Code

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

Signature of Individual or legal guardian

SSA must receive this form within 60 days from the date signed

Date: / /

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

Cefaratti Group
THE LITIGATION SUPPORT COMPANY
From File...To Trial

Social Security Administration - Disability Claims
Attention: Records Custodian

Re:

SS No.:

For the purpose of review and evaluation in connection with a legal claim, you are hereby requested to furnish to Cefaratti Record Retrieval, 4608 St. Clair Avenue, Cleveland, Ohio 44103, a copy of any and all Social Security claim(s), disability or otherwise, together with any Medical Reports or Earnings Records filed with you concerning or in support of my claim from _____ to the present.

I understand that this information may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not apply to psychotherapy notes, psychiatric or psychological records. This consent is subject to revocation at any time except to the extent that action has already been taken thereon. I understand that once my health care information is release, redisclosure of my health care information by the Recipient may no longer be protected by law. I understand that the processing of my claim, my health care, or payment for care will not be affected by whether or not I sign this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records and materials requested herein.

This authorization and consent will expire in one year from the date of authorization written below.

_____ _____

Signature Date

Print Form

Cefaratti Group
THE LITIGATION SUPPORT COMPANY
From File...To Trial

4608 St. Clair Avenue
Cleveland, Ohio 44103

T + 1 216 696 1161
F + 1 216 912 0001

www.cefgroup.com

AUTHORIZATION TO RELEASE UNION RECORDS

MEMBER NAME: _____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER: _____

UNION NAME: _____

UNION ADDRESS: _____

YEARS OF MEMBERSHIP (IF KNOWN):_____

I hereby authorize you to provide to Cefaratti Group, **4608 St. Clair Avenue, Cleveland, Ohio 44103,** a complete copy of all records pertaining to my Union membership and/or employment, including, but not limited to all personnel, payroll, employment history, pension, incident, grievance or accident records pertaining to me.

A copy of this authorization shall have the same force and effect as the original.

This authorization will expire in 1 year from the date designated below and shall be deemed in full force and effect during said time period.

I was employed by the following Employers in the following offices and/or departments:

Employer	Dates of Employment	Department/Office

_____ X_____

Date Signature by Member or Representative

_____

(Relationship if not signed by Claimant)

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial) SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	**TYPE AND EXTENT OF MATERIAL RELEASED**	
	DATE RELEASED	RELEASED BY

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Reocrds" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive reocrds or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructiions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

TO	**Department of Veterans Affairs**	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶

NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

NOTE: *Additional information may be listed on the reverse side of this form.*

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377) www.opers.org

Authorization for Release of Account Information

Ohio retirement law prohibits the release of confidential account information to a third party unless written authorization is provided by the member or retiree. ***You or the third party must contact OPERS separately to request account information****. Use this form to* ***authorize the release*** *of account information as described below. It cannot be used to initiate a request for information. This form will not authorize access to a member's or retiree's MBS account.*

Section 1 - Member Personal Information

Social Security Number

First Name **MI** **Last Name**

Street or Mailing Address **Apt. Number**

City **State** **ZIP Code** -

Home Phone Number **Work Phone Number** **Cell Phone Number**

E-mail Address

Section 2 - Type of Information to be Released - *This information will only be released when you or the third party contact OPERS separately to request account information. Select the records you wish OPERS to release to those you list in Section 3. You can contact OPERS separately by attaching a specific request to this form or by contacting OPERS at 1-800-222-7377 with your request after this form has been received and validated.*

- ☐ Service credit
- ☐ Contributions
- ☐ Earnable salary
- ☐ Value of account
- ☐ Estimate of retirement benefits
- ☐ Income verification
- ☐ Form 1099-R
- ☐ Disability medical records
- ☐ Breakdown of benefits
- ☐ Any/all account information (written and oral)

Section 3 - Person(s) or Entity(ies) to Receive Information - *Complete this Section to designate the person(s) or entity(ies) to receive the information indicated in Section 2. If you wish to designate more than this Section allows, list them on a separate sheet of paper and include their address, phone and fax number. If you are using additional pages, please check this box.* ☐

1. ☐ Physician ☐ Attorney ☐ Authorized Agent

First Name **MI** **Last Name**

Street or Mailing Address

City **State** **ZIP Code** -

Phone Number **Fax Phone Number**

2. ☐ Physician ☐ Attorney ☐ Authorized Agent

First Name **MI** **Last Name**

Street or Mailing Address

City **State** **ZIP Code** -

Phone Number **Fax Phone Number**

Section 4 - Member Authorization

As permitted by Section 145.27, Ohio Revised Code, and Ohio Admin. Code 145-1-61, I authorize the person(s) or firm(s) listed to request and receive the indicated information pertaining to my account with the Ohio Public Employees Retirement System.

This authorization is good *(check one)*:

☐ For 60 days ☐ For 90 days ☐ Indefinitely ☐ Until **Month Day Year**

If a date is not specified, the authorization will be good for 60 days from the date it was signed.

I ask that you honor copies or faxed transmissions of this authorization form. I acknowledge that additionally the original must be sent to OPERS for its membership records. I authorize OPERS to release the data indicated on this form to the person/organization indicated. I understand that I may provide written revocation of this authorization at any time prior to the authorization's expiration as provided above.

I understand that medical records can be released only to my physician, attorney, or agent or the Retirement Board's physician, per Ohio retirement law.

Month Day Year

Member Signature_____

Do not print or type name.

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy**. When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission **must** be provided:

☐ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: **(***Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran **(Must provide proof of death)**.

Show relationship: _____

(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☐ Other (specify) _____

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request ( ) Daytime phone

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

RESET

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	14
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers (including National Guard and Army Reserve on active duty in the U.S. Army)	7	
	National Guard enlisted and officers not on active duty in Army	13	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	**Air Force Personnel Center HQ AFPC/DPSSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721**	**6**	**National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001**	**11**	**Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020**
2	**Air Reserve Personnel Center /DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600**	**7**	**U.S. Army Human Resources Command *www.hrc.army.mil***	**12**	**Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852**
3	**Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804**	**8**	***Reserved.***	**13**	**The Adjutant General (of the appropriate state, DC, or Puerto Rico)**
4	**Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030**	**9**	***Reserved.***	**14**	**National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100 *e*VetRecs! *www.archives.gov/veterans/evetrecs/***
5	**Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400**	**10**	**Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120**		

OMB No. 3095-0039 Expires 7/31/2011

QUESTIONNAIRE ABOUT MILITARY SERVICE

Please complete this form to the best of your ability.

Name(s) used during service (and nicknames, if any):
Last **First** **Middle**

Branch of Service:
☐ Army ☐ Air Force ☐ Navy
☐ Marine Corps ☐ Coast Guard

Veteran's Social Security Number:

Date of Birth:

City and State (Country) of Birth:

Served as:
☐ Officer
☐ Enlisted
If enlisted: ☐ volunteered ☐ drafted
Final Rank:

Serial/Service number(s):

Home Address:
When entered service: City County State
When released from active duty: City County State

Was service six months active duty for training only? ☐ Yes ☐ No

Selective Service: Local Board Number City State Veteran's Selective Service Number

Names of close relatives when military service began (parents, siblings, spouse, children):

Place of enlistment or induction (where veteran took oath of service, such as examining station, reception center, or place of basic training.) Show name of military facility, city, state:

Month/Day/Year began active duty:

Place of basic training and month/day/year began (if different from place and date shown on line above):

Type of military assignment (infantry, airborne, engineer, bombers, fighters, supply, maintenance, food service, etc.):

Last military organization and location (show full unit designations, such as army, division, regiment, battalion, company):

Separation Station (if this service member was released at a separation station after leaving the last "permanent" organization or "unit", include location of separation station):

Month/Day/Year released from active duty

Month/Day/Year of any reenlistment(s) (include full designation and location of unit to which assigned at that time):

If this veteran is deceased, show date of death

Did the veteran ever:

a.	File a claim for VA benefits?	☐ No	☐ Yes	☐ Don't Know	If yes, show VA Claim Number:
b.	Serve in the Reserves after release from active duty period shown above?	☐ No	☐ Yes	☐ Don't Know	If yes, show branch of service show mo/yr from ____ to ____
c.	Receive a state bonus for military service?	☐ No	☐ Yes	☐ Don't Know	If yes, show state ____ mo/yr paid ____
d.	Serve in the National Guard?	☐ No	☐ Yes	☐ Don't Know	If yes, show state ____ ☐ Army ☐ Air show mo/day/yr from ____ to ____
e.	Retire from any military service branch?	☐ No	☐ Yes	☐ Don't Know	If yes, show branch of service show mo/yr retired
f.	Spend time on the Temporary Disability Retired List (TDRL)?	☐ No	☐ Yes	☐ Don't Know	If yes, show branch of service show mo/day/yr from ____ to ____
g.	Serve active duty in any other military service branch in later years?	☐ No	☐ Yes	☐ Don't Know	If yes, show branch of service show mo/day/yr from ____ to ____
h.	Work for the Federal Government as a civilian?	☐ No	☐ Yes	☐ Don't Know	If yes, show agency name show city/state show mo/day/yr from ____ to ____

Purpose: (Optional – An explanation of the purpose of this request is strictly voluntary. Such information may help the National Personnel Records Center to provide the best possible response and will in no way be used to make a decision to deny the request.)

SIGNATURE:

TODAY'S DATE:

DAYTIME PHONE NUMBER: ( )

☞ **Before you send this form, please make sure you have followed the instructions in the "What You Need To Do" section on the other side; otherwise it may not be possible to service this request.**

General Instructions

Purpose of form. Use Form 4506-T to request tax return information. You can also designate a third party to receive the information. See line 5.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different RAIVS teams, send your request to the team based on the address of your most recent return.

Automated transcript request. You can quickly request transcripts by using our automated self help-service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Chart for individual transcripts (Form 1040 series and Form W-2)

If you filed an individual return and lived in:	Mail or fax to the "Internal Revenue Service" at:
Florida, Georgia (After June 30, 2011, send your transcript requests to Kansas City, MO)	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362 770-455-2335
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P. O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on Lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See Internal Revenue Code section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different RAIVS teams, send your request to the team based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
Florida, Georgia (After June 30, 2011, send your transcript requests to Kansas City, MO)	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on Lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

those set forth under the Health Insurance Portability and Accountability Act (HIPAA). In that connection the undersigned waives and releases the Trust from any and all claims, causes of action, lawsuits, or liability of any kind based upon or arising out of the Trusts providing these materials.

Any facsimile, copy, or photocopy of this Authorization shall authorize the Trust to release the records, documents, and materials requested herein.

This authorization will expire in 1 year from the date designated below and shall be deemed in full force and effect during said time period.

_____ X_____

Date Signature by Claimant or Representative

_____

(Relationship if not signed by Claimant)

SWORN TO AND SUBSCRIBED BEFORE ME this _____ day of _____, 201___

X_____

NOTARY PUBLIC

_____

PRINT NAME

My commission expires ___/___/_____

ACKNOWLEDGEMENT

The undersigned, as the party requesting the foregoing records, documents and claims information, hereby represents that the attorney for the Claimant or the Clamant's representative named in the foregoing Authorization has been provided notice that this Authorization will be used to request records from the subject Bankruptcy Trust. Said attorney for the Claimant of the Claimant's representative named in the foregoing Authorization has also been afforded an opportunity to order copies of the records received by the undersigned, provided copying costs are reimbursed.

_____ X_____

Date Signature by Claimant or Representative

MERCY Health Partners

Authorization to Disclose Health Information

Patient Name _____

Health Record Number: Date of Birth:

Facility patient treated at: _____

1 I authorize _____ to disclose the following protected health information about the above-named patient: (include dates where appropriate)

[ ] problem list
[ ] immunization record
[ ] most recent discharge summary
[ ] Consultation report
[ ] entire record (but excluding psychotherapy records, if any exist)' (date) _____ to (date) _____
[ ] Other (describe specifically what is to be disclosed): _____
_____
[ ] for all records from (date) _____ to (date) _____

[ ] medication list
[ ] most recent history and physical
[ ] laboratory results
[ ] x-ray and imaging reports

2. Please send records to:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

3 Purpose: Individual's request

4. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment or testing for alcohol or drug abuse.

5. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the authorized party (#1). I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer with the right to contest a claim under my policy.

6. If I fail to specify, this authorization will expire in six months from the date appearing at the bottom. This authorization will expire on the following date, event or condition: _____.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for the Mercy Health Partners' facilities located in Toledo at 2213 Cherry Street, Toledo, Ohio 43608

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: _____

Witness: _____

Quest Diagnostics

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

For Internal Use:
Date Received _____
Tracking # _____
Initials _____

Quest Diagnostics maintains separate records for each patient visit. The information provided on this request form will be used to search our records. To protect your privacy, we will release the protected health information (PHI) only when our records search results in a match with the information you provide on this form.

In response to this request, Quest Diagnostics will provide copies of test result report(s). This information is also available by contacting your physician and/or your insurance carrier.

Quest Diagnostics relies on information provided by the physician at the time the laboratory test is ordered. The information provided by the physician may not be sufficient to accurately match the information you provide on this Request form. In such cases, Quest Diagnostics will protect our patients' privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Therefore, although the information you provide in this request will assist us to positively identify your records, there is no guarantee that all of your records will be identified. Failure to provide all information we request may prevent us from identifying some of your records.

Patient's Information: (BOLD TYPE indicates Required Information. Incomplete requests will be denied.) REQUIRED

Patient's Name _____ _____ _____ Phone Number (____) _____-_____ Daytime
First Name Middle Name Last Name (____) _____-_____ Evening

All other Names (nicknames, alternate spellings, maiden name, etc.) Gender ρ Male ρ Female

_____ Date of Birth _____ (MM/DD/YYYY)

Address (This is the address where the response will be sent.) Social Security Number _____ (Not required, but may help us to match records)

Street _____

City _____ State _____ ZIP _____ Insurance ID# _____ (Not required, but may help us to match records)

Laboratory Information: (BOLD TYPE indicates Required Information. Incomplete requests will be denied.) REQUIRED

Ordering Physicians' (or Office) Name(s) _____ or Phone Number(s) (____) _____-_____

Address(es) Approximate Date(s) of Service (MM/DD/YYYY)

Authorization: (BOLD TYPE indicates Required Information. Incomplete requests will be denied.) REQUIRED
By signing below you request that Quest Diagnostics search its electronic records and provide you with a copy of the matching PHI maintained on this patient. In certain circumstances, a legal representative of the patient may request information on behalf of the patient. If you are the legal representative of the patient, please provide proof of representation (court order, power of attorney, etc.).

Printed Name _____ Relationship: (Check One)
Γ Self Γ Parent Γ Legal Guardian (Provide Proof) Γ Legal Representative (Provide Proof)

_____
Signature Date

PLEASE SEND MY LAB RESULTS TO: _____

FAX # _____ DR.'S ACCOUNT # _____

ACCESSION # _____ ADDRESS: _____

Contact Us:
Quest Diagnostics generally will respond within 30 days of receipt of this request. Please submit this form (and any proof of representation, if required) to:

Quest Diagnostics
Client Service Department
875 Greentree Road
Pittsburgh, PA 15220

Or FAX to:
412-920-7972

UNIVERSITY MEDICAL CENTER

DEPARTMENT OF MEDICAL INFORMATION MANAGEMENT

University Hospitals
410 West 10th Avenue
Columbus, OH 43210-1228
Phone: (614) 293-8657

Arthur James Cancer Hospital and
Richard Solove Research Institute
300 West 10th Avenue
Columbus, OH 43210-1228
Phone: (614)293-8657

University Hospitals East
1492 East Broad Street
Columbus, OH 43205
Phone: (614) 257-3191

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical Record Number:_____
For Office Use Only

Patient Name:_____ Date of Birth:____/____/____

Social Security Number:_____Telephone Number:_____

I Authorize (check appropriate box):
❑ University Hospitals ❑ OSU & Harding Behavioral Healthcare and Medicine ❑ Dodd Hall
❑ James Cancer Hospital ❑ Clinic ❑ University Hospitals East ❑ Other (please specify):_____

To Release Medical Information To (check appropriate box):
❑ The Ohio State University Medical Center
Med. Info. Management, 140 Doan Hall
410 W. Tenth Avenue
Columbus, Ohio 43210
❑ Other Name:_____
Address:_____

Purpose of Disclosure:_____

Dates of Service:_____

Medical Information To Be Disclosed:
❑ Inpatient ❑ Outpatient ❑ Emergency Department

Specific Reports To Be Disclosed:

❑ Emergency Department Reports	❑ Operative Reports	❑ Assessment
❑ Discharge Summary	❑ Physical/Occupational Therapy Notes	❑ Treatment Plan
❑ Laboratory Reports	❑ Pathology Reports	❑ Progress Notes
❑ History & Physical	❑ Radiology Reports	❑ Admission Note
❑ Other:_____		

I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo, or video has been designated above, if applicable. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 60 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. The revocation of this authorization is effective except as indicated in Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA. I understand that Ohio State University Medical Center cannot condition my treatment or payment for health care on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

X_____ _____
Signature of Patient or Person Authorized to Consent — Date Signed

X_____
Relationship, if not the patient

X_____ _____
Witness (Optional) — Date Signed

For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules Prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

If you have questions regarding release of information from University Hospitals (including OSU & Harding Behavioral Health, University Clinics, and Dodd Hall) or Arthur G. James Cancer Hospital and Richard J. Solove Research Institute call (614)293-8657. If you have questions regarding release of information from University Hospitals East call (614)257-3191. If you have questions regarding copy fees, contact ChartOne Customer Service at 1-800-521-COPY (2679).

Mayo Clinic Number

Name

MAYO CLINIC

TO BE SCANNED
AUTHORIZATION

Authorization to Release Information **BY** *Mayo Clinic*

Purpose for Release of Information —	Patient Date of Birth
☐ Evaluation ☐ Treatment ☐ Placement ☐ Other _____	
Information Being Requested	

I, the undersigned, authorize Mayo Clinic Rochester to disclose any information (all protected health information), or the specific records (outlined above) — (including, but not limited to, information relating to psychiatric/psychologic, sickle cell anemia, and alcohol and drug diagnosis and treatment or information from its affiliated entities, if any such information exists) that it possesses regarding the patient named above being requested to the health care provider, person or institution as follows.

Name of Health Care Provider, Person or Institution Requesting Information			
Mailing Address – Street			
City	State	Zip Code	Telephone Number

As stated in Mayo Clinic's Notice of Privacy, this authorization may be revoked at any time except to the extent that Mayo has taken action in reliance upon this authorization. Revocation must be made in writing to the following appropriate entity: Mayo Clinic, Office of Patient Affairs, 200 First Street SW, Rochester, MN 55905.

Furthermore, I understand that Mayo Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that a copy of this authorization will be provided to me when Mayo Clinic receives the authorization.

I understand, that if this information is disclosed to a third party, the information may be redisclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

I also understand that I may be charged for copies of this information in accordance with state law.

Whichever is shorter, this authorization will terminate in one year or upon the following specified date or event.
Specified Date
Or Specified Event

Signature of Patient	Relationship to Patient (If Not Patient)	Date of Signature
X		
Mailing Address – Street		
City	State	Zip Code	Telephone Number

PATIENT INSTRUCTIONS: *Please complete, sign and date this form where designated above and return Part 1 (original) as directed in attached correspondence (if any) or as instructed by Mayo Clinic staff. Please retain Part 2 for your records.*

GREATER CINCINNATI GASTROENTEROLOGY ASSOCIATES, INC.

2925 Vernon Place
Suite 100
Cincinnati, Ohio 45219

Phone 751-6667

George D. Waissbluth, M.D.
Ronald C. Schneider, M.D.
Michael A. Safdi, M.D. FACP, FACG
Alan V. Safdi, M.D., FACG
Michael D. Kreines, M.D., FACP, FACG
Kris Ramprasad, M.D.
Lisa S. Lestina, M.D.

Kim Richard Jure
David G. Mangels, M.D., FAC
Pradeep Bekal, M.D.
Mark E. Jonas, M.D.
Zahid A. Saeed, M.D., FACG
John P. Czarnecki, M.D.

Date: _____

I hereby authorize and request _____

To release to _____

_____

_____

_____

copies of my medical records in your possession during the period of _____

_____

Name: _____

Date of Birth: _____

Address: _____

_____

Signature: _____

Date Signed: _____

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

HOLZER MEDICAL CENTER
100 Jackson Pike
Gallipolis, OH 45631
(740) 446-5363 Phone
(740) 446-5693 Fax

HOLZER MEDICAL CENTER-JACKSON
500 Burlington Road
Jackson, OH 45640
(740) 395-8307 Phone
(740) 395-8519 Fax

I, _____ hereby authorize _____
(Patient) (Organization)

to release copies of my personal health information concerning my hospitalization or treatment, including but not limited to, information concerning drug related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions, or permit review of the same, provided however, that such release is limited specifically to material of the following nature and extent:

Date of Birth: _____ Date of Service _____

Information to be Released (check all that apply)

_____Face Sheet	_____History and Physical	_____Discharge Summary
_____Lab/Path Results	_____Radiology Reports	_____Radiology Films
_____Consultations	_____Operative Reports	_____Physician Orders
_____Progress Notes	_____Nursing Notes	_____Emergency Department
_____Entire Record	_____Other	

Exclusions (please be specific) _____

The above information is to be released to: _____
(Name of person or organization)

_____
(Address)

_____
(City, State, Zip) (Phone/Fax)

The purpose of the authorized use or disclosure of the information described above is as follows:

_____Continuity of Care	_____Personal Review	_____Insurance
_____Attorney	_____Other (please be specific) _____	

The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization, except in certain stated circumstances. As described in the Notice of Privacy Practices Holzer Medical Center/Holzer Medical Center-Jackson, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by HMC/HMC-J in reliance on this authorization, by sending a written revocation to the MIRS Department at HMC/HMC-J. This authorization will expire in 60 days from the date of signature. A photocopy of this authorization may be used in lieu of the original. I understand that if the person or entity that received the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

_____ _____
Patient Signature Date Other Person Legally Authorized to Give Consent

_____ _____
Witness Relationship to Patient/Reason


* ROI *

76801
Rev 5/04

THE UROLOGY GROUP

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize, The Urology Group/The Urology Center to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits The Urology Group to use or disclosed to _____ the following individually identifiable health
Person or Entity to Receive the Information
information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

_____

This authorization will expire on _____.
(Expiration Date or Defined Event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that The Urology Group has acted in reliance upon this authorization. My written revocation must be submitted to The Urology Group's Privacy Officer at 4700 Smith Rd., Suite L, Cincinnati, OH 45212.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Medic #

AULTMAN HOSPITAL
AUTHORIZATION, RELEASE, AND WAIVER
FOR NON-DUPLICABLE ITEM(S)

FOR PATIENT USE | **FOR HOSPITAL USE**

Patient Last Name:	First Name	Middle Initial	Patient #:	Date of Service:	Type of Visit:

Type of Visit:	Birth Date:	SS#:	Date Item(s) Requested:	Date Released:
__Inpatient __E.R. __Same Day Surgery __Other				

Items to be Released:	Purpose For Disclosure	What Records Were Released? (With Identifying Marks)
____Pathology Slides		_____Pathology Slides _____
____Tissue Samples		_____Tissue Samples _____
____Cytogenetic Slides		_____Cytogenetic Slides _____
____Others, please specify: _____		_____Other, Specify: _____

Name and Employer of Person Receiving Non-duplicable Item(s)	Date:	Released to Whom?	By Whom? (please print)
		(initials)	

I, _____, hereby consent and authorize Aultman Hospital to release to _____
(patient's name) (name of person receiving non-duplicable items)

the following non-duplicable item(s) which were prepared in connection with treatment/care I received while an (inpatient/outpatient) of Aultman
circle one

Hospital on or about_____.
Specify date of relevant admission

Number of:

_____Pathology Slides_____
(slide numbers)

_____Tissue Samples _____
(list identifying marks)

_____Cytogenetic Slides_____
(slide numbers)

_____Other, specify_____
(list identifying marks)

_____Total Items to be Released

I hereby voluntarily waive the statutory physician-patient privilege and the rights to privacy and confidentiality which pertain to these item(s) in the hospital's possession or under its control. Additionally, I hereby release the hospital from any liability arising from disclosure and/or delivery of these item(s) pursuant to this release and waiver.

I acknowledge that the recipient of the non-duplicable item(s) identified above is wholly responsible for any loss of, damage to, or destruction of those item(s) once they have been released to him/her.

By executing this form, I hereby indemnify and hold harmless Aultman Hospital, its directors, officers, employees, servants and agents, of and from all claims, demands, damages, actions, causes of action, or suits, in law or in equity, in contract or tort, known or unknown, of every kind and nature, direct or contingent, in any matter resulting from, arising from, or in connection with the release of these item(s), including but not limited to, claims alleging intentional or negligent loss of, damage to, or destruction of these non-duplicable item(s), as well as claims for the negligent or intentional spoliation of evidence.

In the event these non-duplicable item(s) are lost, stolen, or destroyed, so that they are not returned to Aultman Hospital within the time designated by the applicable Receipt of Non-Duplicable Items, or in the event they are in any way damaged, altered, or tampered with, so that they are returned to Aultman Hospital in a condition varying from the condition in which they were released, I hereby forever release and discharge, for myself, or for my heirs, executors, administrators, successors, assigns, subrogees, or any other persons or entities claiming by or through me, Aultman Hospital, its directors, officers, employees, servants or agents, of and from all claims, demands, damages, actions, causes of action, or suits, in law or in equity, in contract or tort, known or unknown, of every kind and nature, direct or contingent, in any manner resulting from, arising from, or in connection with the medical care and treatment rendered to me at Aultman Hospital during the following admissions: LIST RELEVANT ADMISSION DATES: _____,

including but no limited to, claims alleging medical negligence or malpractice.

I HAVE READ AND DO FULLY UNDERSTAND THIS FORM. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND ALL QUESTIONS RAISED HAVE BEEN SATISFACTORILY ANSWERED. MY SIGNATURE BELOW CONFIRMS MY AUTHORIZATION TO RELEASE THE IDENTIFIED NON-DUPLICABLE ITEMS ON THE TERMS AND CONDITIONS OUTLINED ABOVE, INCLUDING, IN CERTAIN INSTANCES, MY VOLUNTARY RELEASE AND WAIVER OF SPECIFIED CLAIMS.

_____ _____

Signature of Patient Date Signature of Witness Date

If the patient is unable to sign, or is a minor, complete the following:

_____ Patient is a minor _____years of age

_____Patient is unable to sign because of _____

_____ _____ _____

Signature of Parent/Legal Guardian/Authorized Representative Date Relation to Patient
(attach copy of court documents authorizing guardianship or executor of estate status)

FOR USE WHEN ITEMS ARE PICKED-UP IN PERSON

_____ _____ _____

Signature of person receiving items Date Relationship to patient

Rev: 9/04

MRH USE ONLY: This Section completed by MRH personnel.	
☐	Request Approved
☐	Request Denied (Complete Patient Access Denial Form)
☐	NA (Information released to persons other than the patient)
Date:	Initials:

Middletown RegionalHospital
105 McKnight Drive Middletown, Ohio 45044-8787 (513) 424-2111

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/PATIENT ACCESS FORM

Patient's Name: _____ Unit #: _____ Acct #: _____

Birth Date: _____ Social Security Number: _____

Service Date/Type(s): _____
(Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize _____ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

INFORMATION REQUESTED

☐ Face Sheet	☐ Progress Notes	☐ X-ray Reports	☐ Pathology Reports / materials
☐ History / Physical	☐ Physician Orders	☐ Consultation(s)	☐ Operative Reports
☐ Discharge Summary	☐ EKG Interpretations	☐ Laboratory Reports	☐ Copy of Entire Record

☐ Other - Please Specify: _____

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: _____. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

Information to be released to: _____

Address: _____

_____

This information is to be released for the purpose of: ☐ At the request of the patient OR ☐ Other (Please specify below):

_____

I understand that I may revoke this authorization in writing at any time, except if MRH has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Middletown Regional Hospital will not condition the provision of treatment or payment to me on the signing of this authorization, except that Middletown Regional Hospital may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Middletown Regional Hospital may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

Signature of patient or representative: _____ **Date:** _____

If you are the representative of the patient, describe the scope of your authority to act on the patient's behalf. Please check one below:

☐ Guardian ☐ Parent of Minor ☐ Power of Attorney Over Healthcare

This authorization will be accepted up to 60 days from date of signature.

Signature of witness: _____

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider of health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations

A photocopy of this authorization is to be accepted the same as the original.

Bethesda North Good Samaritan

TriHealth

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, [Print Name of Patient] hereby authorize TriHealth, Inc. and The Good Samaritan Hospital of Cincinnati, Ohio (referred to as "Health Care Provider") to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information:

_____

Street Address:

_____

City, State, and Zip Code:

_____

The following individually identifiable health information may be used and/or disclosed:
Check (√) all that apply:

__Discharge Summary

__Reports of Tests & X-rays

__Inpatient Records

__Face sheets with Final Diagnosis, Complications, and Procedures

__Emergency Room Records

__Outpatient Records

__Consultation Reports

__Abstracts

__History and Physical Records

__Immunization (shot) Records

__Physical Therapy Notes

__Outpatient Clinic Notes

__ Billing records including itemized statements

__Other: _____

Dates of Treatment to be released:_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

Your Refusal to Sign this Authorization: The health care provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the health care provider will not withhold treatment from you.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

Expiration: This Authorization will expire sixty (60) days after the date below, or sooner by choice, in which case this Authorization will expire on _____ (insert date on the foregoing line; Note: you may not indicate that there is no expiration, for example the words "does not expire" or "no expiration" or "none" are not acceptable).

Revocation: I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to the Medical Records Manager for TriHealth located at the Good Samaritan Hospital, 375 Dixmyth Avenue, Cincinnati, Ohio 45220. If this Authorization allows the release of billing records and I wish to revoke the authorization to use and/or disclose my billing records, I understand that I may revoke by sending a letter to the Director, Patient Accounting, TriHealth, Inc., 619 Oak Street, Cincinnati, Ohio 45206. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.

_____ _____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE PHONE #

*Patient's Date of Birth:_____
*Patient's Social Security Number:_____
*The above Information is required in order to verify the identity of the patient and locate the patient's protected health information.

Printed name of patient's representative, if applicable: _____
Relationship to patient: _____

Please note that there will be a charge to copy records that are not being sent to a physician or health care facility for further medical care. TriHealth may use a copy service and it may bill you directly.

FOR INTERNAL PURPOSES ONLY

STAFF: This Authorization DOES NOT PERMIT the disclosure of notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's health record. This Authorization DOES PERMIT the disclosure of other psychotherapy/mental health records including medication prescriptions and monitoring; counseling session start and stop times; modalities and frequencies of treatment furnished; results of clinical tests; and, a summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

WHEELING HOSPITAL, INC
MEDICAL PARK
WHEELING, WV 26003

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____

PATIENT'S ADDRESS: _____ SOCIAL SECURITY #: _____

_____ TELEPHONE #: _____

MAIDEN/OTHER NAMES: _____

I authorize: ☐ Wheeling Hospital / ☐ _____
to release all information contained in my medical records, including alcohol and drug abuse records (if any); mental health and/or psychological service record (if any); information about serious communicable diseases and infections which include human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS-related complex (ARC); and social services records (if any) to the individual(s) or organization(s) listed below under the conditions specified below:

1. Name of person(s) or organization(s) to whom disclosure is to be made: ☐ Wheeling Hospital Medical Park, Wheeling, WV 26003

OR: _____
(Name) (City) (State) (Zip Code)

2. Specific date(s) of hospitalization/treatment and specific type of information to be disclosed:

_____

_____

3. Purpose and need for such disclosure: _____

_____

4. Consent will expire on: _____
(One year from date of signature if not specified.)

5. I understand that I may revoke this authorization in writing at any time except to the extent that Wheeling Hospital, Inc. has already relied on this authorization.

6. I understand that protected health information, once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA privacy standards and may no longer be protected by HIPAA.

7. I understand that Wheeling Hospital, Inc. may not condition treatment on my completion of this authorization form.

_____ Date: _____
Signature of Patient or Parent (if patient is a minor) or
Personal Representative, Legal Guardian or Closest Relative, if patient unable to sign: Reason: _____

_____

Witness: _____ Date: _____

MEDICAL UNIVERSITY
OF OHIO

HEALTH INFORMATION MANAGEMENT

Phone Number (419) 383-3864 Fax Number (419) 383-3001

Mailing Address: Health Information Management - Release of Information Unit
Medical University of Ohio
Dowling Hall, Room 70
3065 Arlington Ave
Toledo, Ohio 43614

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information	Recipient Information
Patient Name:_____	Recipient Name:_____
Birth Date:_____ SS#_____	Address:_____
Med Record Number (optional): _____	_____
Address:_____	_____
_____	_____
_____	Phone :_____
Phone:_____	

1. **I hereby authorize Medical University of Ohio, its Agents and its Employees to release Protected Health Information about Me/My child to the recipient which may include test results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation [42CFR Part 2], if any, and mental health information, if any.**

2. Information To Be Disclosed: (check all that apply)

_____Outpatient Surgery	Date of Service: _____
_____Inpatient Admission	Date of Service: _____
_____Clinic or Office Visit	Date of Service: _____
_____Emergency Department Visit	Date of Service: _____

Specific Reports To Be Disclosed: (check all that apply)

_____Discharge Summary	_____Radiology/Ultrasound Reports
_____History and Physical	_____Pathology Reports
_____Operative Reports	_____Laboratory Reports
_____Emergency Department Report	_____Physician Progress Notes
_____Psychotherapy Notes	_____Complete Set of Medical Records

_____Other _____

3. Purpose of Disclosure: ___Continuation of Care ___Request of Patient Other (specify) _____

4. Information To Be:

_____Copied and Mailed	_____Viewed
_____Copied and Picked Up	_____Shared

5. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoke, this authorization is valid for 60 days.
6. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
7. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
8. MUO may not condition my treatment or payment on my signing this document.
9. I have been informed that copies of my medical record(s) are subject to a copying fee. I have been informed that the Medical University of Ohio utilizes an outside contracted copy service.
10. A Photocopy is as valid as the original.
11. Date of next appointment if known: _____

Signed: _____ _____ _____ _____
(Patient or Person Authorized to Consent) Date *(Witness Optional)* Date

_____
(Relationship to patient and authority to act in the patient's behalf)