Washington County Dept. of Job & Family Services
1115 Gilman Ave., Marietta, Ohio 45750
(740) 373-5513

Authorization for the Release or Use of Protected Health Information (PHI)

Name:	**Soc. Sec. No**
Address:	**Date of Birth:**
City, State, Zip:	**Sex**
Case Worker:	**Case No**

I, _____, hereby authorize _____ to disclose protected
(Name of individual) (Entity releasing PHI)

health information to **Washington Co Dept of Job & Family Services** for the purpose of **personal reasons.**
(Entity receiving PHI) (Describe why this information is being released)

Information is to be mailed to: Street**: 1115 Gilman Avenue** City: **Marietta** **Ohio** Zip Code: **45750**

Is this information being released for an insurance claim? **X** NO _____ YES **(If YES, see Section II on reverse side.)**

SECTION B:

The specific protected health information to be released is: **Last eighteen months of all medical data available which includes: out- patient & in-patient medical reports, test & x-ray results, information regarding drug and/or alcohol abuse, testing for or infection with HIV, and any psychiatric or psychological conditions, etc.**
(What information should be released?)

SECTION C: By signing below, I understand that:

- This authorization shall expire on _____ or until revoked by me in writing, whichever comes first.
(Date)
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to:
Washington County DJFS 1115 Gilman Avenue Marietta, Ohio 45750
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- I am not required to sign this authorization. If I refuse to sign this form, it will not affect my Medicaid eligibility, my eligibility for other programs such as Disability Assistance Medical, Refugee Medical, or Healthy Start Healthy Families or my application for such programs.
- I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
- If by law we cannot send the protected health information to the entity listed above, please initial in the following space if you want a copy of the information sent to you directly:_____.

SECTION D:

X	
Signature of Individual or Authorized Representative	Print name of individual
Representative's legal authority to individual	Print name of Authorized Representative

Today's Date:

***** Important information and instructions for completing this form are on the reverse side.*****

IMPORTANT INFORMATION AND INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

I. The Ohio Department of Job and Family Services or a county agency may release information pursuant to this signed authorization only if the form is completed thoroughly and all conditions listed on the completed form are met. Furthermore, information concerning the receipt of medical assistance under Chapter 5111, Chapter 5115, section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code may be released only if both of the following apply:

A. The release of information is for purposes directly connected to the administration of programs created under Chapter 5111, Chapter 5115, section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code or services provided under programs created under these chapters;

B. The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for programs created under Chapter 5111, Chapter 5115, section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code.

II. If the information being released is for an insurance claim, it is important to note that as per Ohio Administrative Code (OAC) rule 5101:3-1-08(D), the department (ODJFS) has subrogation rights pursuant to section 5101.58 of the Revised Code (Medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by the department, or billable to the department for payment at a later date.

III. Instructions

Section A:

1) "Name," "Address," and "Billing Number" of the individual whose protected health information (PHI) is being released. If the form is being completed by an authorized representative or other legal authority, enter the name and address of the authorized representative or legal authority and enter the billing number of the individual whose PHI is being released. If the billing number is not known, enter the "Social Security Number" of the individual whose PHI is being released.
2) "Name of individual" is the individual whose PHI is being released.
3) "Name of covered entity, such as 'ODJFS,'" is the agency or organization who has the individual's PHI which will be released.
4) "Who will receive the information?" is the person or organization who will obtain the PHI when it is released.
5) If the PHI being released is being released for an insurance claim, please see the important information in section II above regarding Ohio Administrative Code (OAC) rule 5101:3-1-08.
6) "Describe why this information is being released" means that you need to write why the PHI is being released to a third party.
7) Ensure to provide a complete address for the entity you want to receive the information.

Section B: Thoroughly specify what PHI is being released. Federal regulations (45 CFR 164.502) require that only the MINIMUM NECESSARY information needed to accomplish the intended purpose may be released.

Section C: The signed authorization is valid until the completion of the "event" or until it is revoked in writing by the individual who signed it, whichever comes first. "Event" may be defined as the reason the signed authorization is needed. For example, if the signed authorization is needed for an insurance claim to be processed and paid, the signed authorization is only valid until that occurs. It is recommended that the length of an authorization not exceed one year. In some situations the law may not allow us to release information to the entity you specified. If in such a situation you want us to instead mail copies of the protected health information directly to you, write your initials in the space provided.

Section D: The individual whose PHI is being released should sign and date the form. However, if the individual is not able to sign the form, the individual's authorized representative should sign and date it. If the form is signed by an authorized representative, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released.