THIS FORM MUST BE COMPLETED IN THE ENTIRETY
BY THE PATIENT OR THE PATIENT'S AUTHORIZED
REPRESENTATIVE

TRIHEALTH, INC. AND TRIHEALTH AFFILIATED PRACTICES AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Maiden Name
Social Security Number ☒Date of Birth	Phone Number
Address	

1. Provider Making the Use or Disclosure**:** I authorize **TriHealth** (referred to as "Health Care Provider") to release my/the patient's individually identifiable health information as described below.

2. Recipient of the Information: I authorize the Health Care Provider to release the information described in this authorization to: (place your initials beside each one you authorize)

   _____ Dean of Students Office, Miami University, Oxford, Ohio
   _____ Testing Team, Miami University, Oxford, Ohio
   _____ Saliva Lab, Miami University, Oxford, Ohio
   _____ Enrollment Management Student Success, Miami University, Oxford, Ohio
   _____ Athletics, Miami University, Oxford, Ohio

3. Type of Information to be Released: Describe the type of information that you want to be disclosed pursuant to this Authorization-

   A. **MEDICAL RECORDS:** (Check "All Medical Records" or "Other")
   ☐ ALL MEDICAL RECORDS; *or*
   ☐ OTHER-I only want the following parts of my medical record to be disclosed:
   COVID TEST RESULTS

   B. **BILLING RECORDS:** (Check if you want billing records released)

   ☐ All billing records, including itemized statements

   C. **DATES OF TREATMENT:** (Check "All dates of Treatment" or "Specific dates of treatment")
   ☐ All dates or treatment; *or*
   ☐ Specific dates or treatment: I only want records for the following dates of treatment to be disclosed: _____

Further, 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 Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric /psychological conditions and/ or psychiatric/mental health treatment.

4. 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 and will not release the information to the person or organization specified above.

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5. Purpose for the Use or Disclosure: The purpose for the disclosure is at the patient's request.

6. Oral Communications: I understand that this Authorization allows the Health Care Provider (and its employees) to discuss my individually identifiable health information described herein with the recipient of the information.
7. 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 patient 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

8. **Revocation:** I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

9. Expiration: This Authorization will expire one year after the date below, or sooner by choice, in which case this Authorization will expire on_____(If applicable, 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). However, if the records to be used or disclosed pursuant to this Authorization concern psychiatric, psychological and or mental health treatment, this Authorization will expire 90 days after the date below, or sooner by choice, in which case this Authorization will expire on _____(If applicable, 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).

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

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

Relationship to patient:
☐ Parent ☐ 'Legal Guardian ☐ 'Other: _____

'Legal documentation of Representative's authority must accompany this Authorization.

Please note that there may be a charge to copy records.
The Health Care Provider may use a copy service and it may bill you directly.

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 during 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.