GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby authorize the use or release of personal health information about me as described below. I understand that copying charges may apply. (Copying charges are identified on the reverse side of this form.)

1. Information to be accessed or released: (check all that apply)

☐ Discharge Summary	☐ ER Chart	☐ Physician Orders
☐ History & Physical	☐ Urgent Care Chart	☐ Progress Notes
☐ Consultation	☐ Laboratory Reports	☐ All Dictated Reports
☐ Operative Report	☐ Medical Imaging Reports	☐ Other (specify):
☐ Discharge Instruction Sheet	☐ EKG	___
		___
		___

From my visit of (Date of Service or Acct #):
___

2. My personal health information may be accessed or released to: _____
   - ☐ Mail copies of information
   - ☐ Pick up copies of information
   - ☐ Send summary of information
   - ☐ Inspect originals
   - ☐ Electronic copy
   - ☐ Fax copies of information to Healthcare Provider
   - ☐ Fax copies of Lab Results to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____
   - ☐ Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

3. Purpose of the use or release:
   - ☐ Patient request
   - ☐ Marketing, if so remuneration to GLHS:
   - ☐ Other (describe): _____

4. I understand that if the person or entity that receives 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 the federal privacy regulations.

5. I understand that the information in my health records may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

6. As described in the Notice of Privacy Practices of GLHS, I understand that I may revoke this authorization, except to the extent that action has been taken by GLHS in reliance on this authorization, by sending a written revocation to GLHS, 200 St. Clair Street, St. Marys, Ohio 45885: Attn: HIM.

7. This authorization is valid for 60 days, unless otherwise specified. ☐ 1 yr ☐ 5 yrs ☐ 10 yrs ☐ upon death

8. I understand that I am not required to sign this authorization form and that GLHS will not condition the provision of treatment or payment to me on the signing of this authorization. GLHS may condition the provision of health care to me that is solely for the purpose of creating protected health information for release to a third party on the signing of this authorization.

_____	_____
Patient Name (Print)	Identifier (Date of birth, service, etc.)
_____	_____
Legal Representative (Print)	Relationship (Parent, DPOA, Guardian)
_____ _____	_____ _____
Signature of Patient or Representative — Date	Employee Signature — Date

COPYING FEES

All other requests, i.e. attorney, insurance, etc.:

$ 22.25 record search fee.
$ 1.53 per page for first ten pages.
$ .79 per page for pages eleven through fifty.
$ .31 per page for pages fifty-one and higher.

Medical Images

$ 2.48 per page