Ohio Department of Health

Authorization for Disclosure of Health and Other Privileged Information

1. I hereby authorize The Ohio Department of Health to release the information described herein. Furthermore, I certify that I'm legally entitled to this information as I am the (check one of the following):

   a) ☐ Power of Attorney for Healthcare (POA) for the individual named below.
   Please include a copy of your driver's license and the POA.

   b) ☐ Executor/Executrix of the estate for the individual named below.
   Please include a copy of your driver's license and Letters of Authority.

   c) ☐ Individual who filed a complaint against the healthcare facility identified below.
   Please include a copy of your driver's license and specify the control number(s) assigned by the ODH complaint intake staff.

Control number	Master control number

2. Information to be disclosed ***(check the items you wish to obtain)***

Facility name		
Facility location		
Survey date (if known) month	day	year

☐ Statement of Deficiencies and Plan of Correction ☐ Report of Investigation of Complaint
☐ Surveyor Notes ☐ Health Assessment ☐ Resident Interview
☐ Any other documents on file that may mention the identified resident/complainant.

I understand that this information may contain medical diagnoses relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychiatric care, treatment for alcohol and/or drug abuse.

Please initial.

3. This information is to be disclosed to _____ for the purpose of

_____ at the following address:

Name		
Street address		
City	State	ZIP

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

_____

5. The Ohio Department of Health and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or legal representative	Date	Signature of witness	Date

HEA 1140 (5/00)