ALLIED INFOTECH CORPORATION
DOCUMENT STORAGE AND MANAGEMENT

Authorization For Release Of Protected Health Information

Please PRINT and fill out the entire form.

Patient Information

Patient Name: _____ _____
Last First Middle (any previous name) Date of Birth

_____ _____
Patient Street Address City State Zip Phone

Release From

Release Information **FROM** the following Person(s) or Organizations:

Name/Organization:_____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Release To

Release Information **TO** the following Person(s) or Organizations:

Name/Organization:_____ Attention:_____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):
- ☐ Patient/Parent/Legal Guardian
- ☐ Doctor/Hospital
- ☐ Lawyer
- ☐ Insurance
- ☐ Other_____

Purpose of Release (check all that apply):
- ☐ Patient Care
- ☐ Disability
- ☐ Insurance
- ☐ School
- ☐ Legal
- ☐ Personal Use
- ☐ Other _____

Method of Release

Format of records to be released: ☐ On Paper

Information May Be Sent Via: ☐ Mail Delivery (UPS) ☐ Fax ☐ Encrypted Email

Information to Release

Dates of Treatment Requested:_____ (if not specified, the **LAST 6 MONTHS** will be released)

- ☐ All PHI in medical record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Ambulance Run Sheet
- ☐ Consult
- ☐ X-Ray Report
- ☐ Lab/Pathology Report
- ☐ Operative Report
- ☐ Cardiac Cath Report
- ☐ Physical Therapy
- ☐ EKG/Rhythm Strips
- ☐ Nursing Information
- ☐ Discharge/Transfer Form
- ☐ ER Information
- ☐ Labor/delivery sum.
- ☐ OB nursing assess
- ☐ Postpartum flow sheet
- ☐ Itemized bill
- ☐ UB-92
- ☐ Other

Patient/ Parent/ Legal Guardian

This authorization expires one year from the date of signature, OR on this date/event:_____

I understand that treatment does not depend on me signing this Authorization. I understand that my medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Allied Infotech Corporation at 2170 Romig Road, Akron, Ohio 44320.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

MANDATORY My relationship to the patient is: ☐ Self ☐ Parent ☐ Legal Guardian-if this box is checked, you must attach Court Order to show your authority to sign*

	_____ Signature of Patient or Parent/Legal Guardian	_____ Printed Name	_____ Date
	_____ Signature of Witness	_____ Printed Name	_____ Date

Payment Information

Allied Infotech Corporation is classified as a Medical Records Company as referenced in the Ohio Revised Code Section 3701.741 “Fees for providing copies of medical records”. Upon processing this release of information form, Allied Infotech will calculate the total cost to duplicate the medical record. An Allied Infotech representative will contact the form’s applicant to review the total cost. Payment of these services must be made prior to the release of records. Allied Infotech only accepts all major credit cards for this service.

If the request is made by the patient or the patient’s personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

For the first ten pages: $3.62/page
For pages eleven through fifty: $0.76/page
For pages fifty-one and higher: $0.30/page

The actual cost of any related postage incurred by the Medical Records Company will be invoiced at actual cost.

If the request is made other than by the patient of the patient’s personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

An initial fee which shall compensate for the records search $22.33

For the first ten pages: $1.47/page
For pages eleven through fifty $0.76/page
For pages fifty-one and higher: $0.30/page

The actual cost of any related postage incurred by the Medical Records Company will be invoiced at actual cost.

Submit

Submit completed form AND a copy of a valid Photo ID to:

Mail form to:	**Fax form to:**	**Email form to:**	**Questions?**
Allied Infotech Corporation Release of Information 2170 Romig Road Akron, Ohio 44320	330-753-5017	release@alliedinfotech.com	Call 330-753-8383

Rev. 7/2023

Allied Infotech Corporation (Internal Use Only)	
Release of Information Received (ROI) Date	**Date** _____
Method of receiving ROI	☐ **Mail** ☐ **Fax** ☐ **Email**
Number of pages	**Total** _____
Payment received by	**Initials** _____ **Date** _____
Request completed by	**Initials** _____
Date ROI sent from AIC	**Date** _____