

Authorization for Use or Disclosure of Information

*This form must be filled out completely and either scanned and uploaded via the Portal, or mailed to:
Crime Victims Services, 30 E. Broad St. Fl26, Columbus, OH 43215-9853*

Patient's Name

Date of Birth

Social Security Number

Address

City

State

Zip

Victim/Claimant's Name

I, _____, hereby voluntarily authorize the disclosure of information from the above patient's health record. I authorize the disclosure or use of **THE PATIENT'S ENTIRE RECORD**, excluding psychotherapy notes.

This information is to be disclosed by any covered entity, including any physician, medical facility, health care provider, mental health care provider, insurance company, billing department, health care clearinghouse, health plan or pharmaceutical entity, employer organizations, Ohio Department of Job and Family Services, Child Support, law enforcement or governmental agency, upon request to release and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney a copy of any report, document, record, or other information (including tax information or medical information). This information is to be used in any way necessary related to my claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that the covered entity from which the Ohio Attorney General seeks to obtain records may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that failing to provide my Social Security number may significantly impede the processing of my claim.

I understand that the Ohio Attorney General is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, I understand that the Ohio Public Records Act (Ohio Revised Code Section 149.43) prohibits the Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations.

I understand that disclosure of confidential information from medical records may be protected by state or federal law. If applicable, state law (Ohio Revised Code Section 3701.243) and federal regulations (42 CFR part 2) prohibit the Ohio Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations. This authorization or a copy hereof shall be valid for a period of two years without any further consent by me.

This authorization complies with the requirements of 45 CFR 164.508, HIPAA, and the HIPAA Privacy Rule.

A photocopy or facsimile copy of this authorization release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

Victim/Claimant's Signature

Date

Claimant's Relationship to Victim