A close up of a logo

Description automatically generated**RECORDS REQUEST FORM**

**1. Patient Information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name (First, Middle, Last)** | | | | **EHP ID#** | | | |
| **Current Address** |  | **City** | |  |  | **State** | **Zip** |
| **Email** | | | **Phone Number**  **( )** | **Date of Birth**  **/ /** | | |
| **2. Release Information To:** | | | | | | | |
| **Name of Recipient** | | | | | | | |
| **Address** |  | **City** | |  |  | **State** | **Zip** |
| **Phone Number: (** | **)** |  | | **Fax Number: (** | **)** |  |  |
| **Check delivery option desired**   * Paper * Secure electronic delivery (provide recipient’s email) | | | | | | | |

# Purpose for Disclosure:

**(Purpose for disclosure must be completed prior to processing; e.g. continuing care, personal use, legal)**

**Date(s) of Service to Release (FROM): (TO):**

* Medical Management (describe service type; MRI, CT scan, name of drug, etc.)
* Pharmacy Management
* Claims
* Healthy Choice
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, authorize EHP to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS- related conditions and/or alcohol/drug abuse. **\*This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. \*Release of Psychotherapy Notes requires a separate authorization.**

**This authorization and consent will expire one year from the date of authorization written below**, unless revoked by me (or my legal representative) through written notice presented to EHP (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service for releasing medical information. There is no charge to send records directly to my health care provider.

**If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed. Please allow for up to 30 days for processing.**

# / / /

Signature of Member/Member’s Personal Representative\*\* Printed Name Date Signed

Relationship, if not Member

\*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the result of a patient’s medical records.

\*\*If other than the member’s signature, a copy of legal paperwork verifying the member’s personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.

\*\*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.

**Submit Request to the Following**:

* 1. Employee Health Plan (2) Fax: 1-216-442-5792

25900 Science Park Dr./AC242

Beachwood, OH 44122

216—986-1050

11/30/2024