Ohio Tort Recovery Unit

AUTHORIZATION FOR THE RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)

FOR OFFICE USE ONLY	
Tracking #	
Date Received	_____
Approved/Denied By and Date	_____

SECTION A:

Name:	**Address:**
Billing Number:	
Social Security Number: (Optional - see reverse side)	

I, _____ , hereby authorize, Ohio Medicaid, Tort Recovery Unit to
(Name of Individual) (Name of Covered Entity)

disclose protected health information to Lien Resolution Group , for the purpose of _____
(Who ill receive the information)

to substantiate Medicaid's lien relating to a lawsuit.
(Describe why this information is being released)

The Protected Health Information (PHI) is to be mailed to: Street _55 Old Nyack Turnpike Rd. Ste. 311_
City Nanuet State NY Zip Code 10994

Section B:

The specific health information to be released Is:_____

_____
(What information should be released?)

Section C: By signing below, I understand that:

- This authorization shall expire on _____ or until revoked by me in writing, whichever comes first
  (Date or completion of "event")
- I have the right to revoke or cancel this authorization at anytime by providing notice in writing to this office.
- If I revoke or cancel this authorization, it is not effective for use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- I am not required to sign this authorization.
- I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
- If by law we cannot send the protected health information to the entity listed above, please initial in the following space if you want a copy of the information sent to you directly: _____ .

_____

Section D:

Signature of individual or authorized representative	**Print name of individual:**
_____	_____
Representative's legal authority to individual	**Print name of individual:**
_____	_____

Today's Date:

Photocopy must be given to individual or individual's authorized representative.

***** Important information and instructions for completing this form are on the reverse side. *****

Important Information and Instructions for Completing

I.

_____

(Name of Covered Entity)

II. Instructions Section A:1) “Name,” “Address,” and “Billing Number” of the individual whose protected health information (PHI) is being released. If the form is being completed by an authorized representative or other legal authority, enter the name and address of the authorized representative or legal authority and enter the billing number of the individual whose PHI is being released. If the billing number is not known, enter the “Social Security Number” of the individual whose PHI is being released.2) “Name of individual” is the individual whose PHI is being released.3) “Name of covered entity’” is the agency or organization who has the individual’s PHI which will be released.4) “Who will receive the information?” is the person or organization who will obtain the PHI when it is released.5) “Describe why this information is being released” means that you need to write why the PHI is being released to a third party.6) Ensure to provide a complete address for the entity you want to receive the information.

Section B: Thoroughly specify what PHI is being released. Federal regulations (45 CFR 164.502) require that only the MINIMUM NECESSARY information needed to accomplish the intended purpose may be released

Section C: The signed authorization is valid until the completion of the “event” or until it is revoked in writing by the individual who signed it, whichever comes first. “Event” may be defined as the reason the signed authorization is needed. For example, if the signed authorization is needed for an insurance claim to be processed and paid, the signed authorization is only valid until that occurs. It is recommended that the length of an authorization not exceed one year. In some situations the law may not allow us to release information to the entity you specified. If in such a situation you want us to instead mail copies of the protected health information directly to you, write your initials in the space provided.

Section D: The individual whose PHI is being released should sign and date the form. However, if the individual is not able to sign the form, the individual’s authorized representative should sign and date it. If the form is signed by an authorized representative, the representative’s “legal authority” to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released.

FOR OFFICE USE ONLY box: The Covered Entity's HIPAA Compliance Officer should assign a tracking number when the authorization form is received, enter the date the form was received, circle either "Approved" or "Denied", initial next to the "Approved" or "Denied," and enter the date the form was "Approved" or "Denied."