Ohio Department of Medicaid

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

FOR STATE 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 ODM to disclose
(Name of Individual) *(Name of covered entity, such as "ODM")*

Protected Health information to The Law Office of Christine LaSalvia for the purpose of Legal Review
(Who will receive the information?) *(Statement of the purpose for this release or disclosure)*

Information is to be mailed to: The Law Office of Christine LaSalvia

Street	City	State	Zip Code
614 W. Superior Ave., #820	Cleveland	Ohio	44113

Is this information being released for an insurance claim?

☐ NO ☐ YES *(if YES, see Section II on Page 2.)*

SECTION B:

The specific protected health information to be released is: *(Description of the information to be released, please be specific)*

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 this authorization at any time by providing notice in writing to: Ohio Department of Medicaid, Attn: Health Information Privacy Official, P.O. Box 182709, Columbus, Ohio 43218-2709.
- If I revoke or cancel this authorization, it is not effective for the 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 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: _____

Signature of Individual or Authorized Representative	Print Name of Individual
Representative's Legal Authority to Individual	Print Name of Authorized Representative

Today's Date

Distribution: Send completed form to: Ohio Department of Medicaid, Attn: Health Information Privacy Official, P.O. Box 182709 Columbus, Ohio 43218-2709.

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