

Ohio Department of Medicaid  
**AUTHORIZATION FOR THE RELEASE  
 OR USE OF PROTECTED HEALTH INFORMATION (PHI)  
 OR OTHER CONFIDENTIAL INFORMATION**

<b>FOR STATE USE ONLY</b>
Tracking #
Date Received Approved/Denied by and Date

**SECTION A:**

Name	Address
Billing Number	
Social Security Number <i>(Optional-see reverse side)</i>	

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to disclose  
*(Name of Individual)* *(Name of covered entity, such as "ODM")*  
 Protected Health information to \_\_\_\_\_ for the purpose of \_\_\_\_\_  
*(Who will receive the information?)* *(Statement of the purpose for this release or disclosure)*

Information is to be mailed to:

Street	City	State	Zip Code
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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.\*\*\***

**IMPORTANT INFORMATION AND INSTRUCTIONS FOR COMPLETING ODM 03397, AUTHORIZATION FOR THE RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)**

- I. The Ohio Department of Medicaid or a county agency may release information pursuant to this signed authorization only if the form is completed thoroughly and all conditions listed on the completed form are met. Furthermore, information concerning the receipt of medical assistance under Chapter 5111, Chapter 5115, Section 5101.49 of the Ohio Revised Code and sections 5161.05 through 5161.35 of the Ohio Revised Code may be released only if both of the following apply:
  - A. The release of information is for purposes directly connected to the administration of programs created under Chapter 5160 and 5161 of the Ohio Revised Code.
  - B. The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for programs created under Chapter 5111, Chapter 5115, section 5101.49 of the Ohio Revised Code and sections 5161.05 through 5161.35 of the Ohio Revised Code.
- II. If the information being released is for an insurance claim, it is important to note that as per Ohio Administrative Code (OAC) rule 5160-1-08, the department has subrogation rights pursuant to section 5160.37 of the Ohio Revised Code (Medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by the department, or billable to the department for payment at a later date.

**III. 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, such as 'ODM,'" 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. If the PHI being released is being released for an insurance claim, please see the important information in section II above regarding Ohio Administrative Code (OAC) rule 5160.-1-08.
6. "Statement of the purpose for this release or disclosure" means that you need to write why the PHI is being released to a third party.
7. 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.