Interview Consent Process and Forms

Date: Feb. 6, 2012

If you are conducting an interview or photo session or videotaping a patient, or their family member, for a story that could appear in the news media, advertising, internal publication, on the web or anywhere else that could be considered public, you need to have the interviewee sign ONE and possibly TWO of the following consent forms.

"CONSENT TO RECORD" (ALWAYS)

You must ALWAYS have the interviewee sign the "Consent to Record" form. This form says that the interviewee acknowledges that they understand they are being interviewed and give their permission for the interview to take place and for the interview to be shared with the public.

Once it is filled out, submit one copy to their medical record and keep an additional copy in your files.

"AUTHORIZATION TO RELEASE INFORMATION" (IF PHI IS SHARED)

If the topic of the interview will include discussion of the interviewee's protected and personal health information, then they must ALSO fill out the HIGHLIGHTED areas only of this document and sign. This is the same document used system-wide OhioHealth.

Once it is signed, a copy must be placed in the patient's medical record and you should keep an additional copy in your files as well.

If you have any questions about this, please call the MEDIA RELATIONS Dept. 614-544-4259.

❑ Riverside Methodist Hospital ❑ Grant Medical Center ❑ Doctors Hospital

❑ Grady Memorial Hospital ❑ Dublin Methodist Hospital ❑ Other _____

I voluntarily give my permission for photographs, film, videotape, written interview or other recording to be taken of me and to publish same without incurring any debts or liabilities to me. I understand the nature of the interview session and understand that I will receive no compensation or fee. I give permission voluntarily and have full authority to give consent.

The recorded interview may be used in one or more of the following: news media, internal publication, medical publication, OhioHealth web site or other.

Description of topic to be discussed:

_____

_____

I understand that once the interview materials are released to the news media, OhioHealth retains no further control over their use.

I understand that I am not required by OhioHealth to sign this authorization form and that authorization is not a condition for treatment.

Print Name _____ Date_____ Time _____
(check one) ❑ PATIENT ❑LEGAL GUARDIAN ❑ ASSOCIATE ❑ OTHER

Signature _____

Address _____

Phone Number _____ Email _____

Signature of OhioHealth Representative _____

Communications Department
180 E Broad Street, 30th Floor
Columbus, Ohio 43215
(614) 544-4259

This form must be placed in the patient's chart.

OhioHealth

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PATIENT IDENTIFICATION LABEL

CONSENT TO RECORD PHOTO VIDEO OR AUDIO INTERVIEW

***For media, marketing or other public disclosure uses, just fill out the highlighted areas and send a copy to Medical Records.**

Authorization to Release Information

MRN

1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MAIDEN

ADDRESS	CITY	STATE	ZIP

DOB	SOC.SEC.	WORK PHONE	HOME PHONE

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

❒ CONTINUITY OF CARE / MEDICAL TREATMENT (Minimum Document Set section below)
❒ DISABILITY(Minimum Document Set section below)
❒ CONTINUITY OF CARE (Minimum Document Set section below)
❒ CHANGING DOCTOR / MOVING FROM AREA (Minimum Document Set section below)
❒ OTHER (Specify)_____
❒ EMPLOYMENT RELATED
❒ INSURANCE
❒ LEGAL REASONS
❒ ADOPTION PLANNING
❒ RESEARCH
❒ PUBLIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (IF yes- SKIP TO SECTION 6)

3. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM: (check as many as applicable)

❒ Riverside Health Center
❒ Riverside Methodist Hospital
❒ Grant Medical Center
❒ Grady Memorial Hospital
❒ Doctors Hospital
❒ McConnell Health Center
❒ Dublin Methodist Hospital
❒ HomeReach
❒ Hardin Memorial Hospital
❒ Marion General Hospital
❒ Gerlach Center
❒ Westerville Medical Campus
❒ Doctors Hospital Nelsonville
❒ Medical Specialty Foundation (name of practice/provider)_____
❒ Outpatient /Neighborhood Care Health Centers (name of practice/provider) _____
❒ Other _____

SPECIFY TYPE OF RECORD REQUESTED: **DATE OF SERVICE(S):**

❒ INPATIENT _____
❒ OUTPATIENT CARE CLINICS _____
❒ EMERGENCY ROOM _____
❒ OUTPATIENT _____
❒ OTHER _____

❒ DATES/SERVICES TO BE EXCLUDED FROM RELEASE (i.e. ***HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS that may be in your medical record.***
Please specify : _____

4. RECORDS/DOCUMENTS (CONTENT)

Content to be Released – For the record(s) selected above, specify content in area below, as either, Complete Record, minimum document set or additional document set. Each type of record may or may not contain all of the documents listed above.

❒ **COMPLETE RECORD**

MINIMUM DOCUMENT SET (check one or more of the documents, or all)
❒ FACESHEET
❒ DISCHARGE SUMMARY
❒ HISTORY AND PHYSICAL
❒ CONSULTS
❒ OPERATIVE REPORTS
❒ EMERGENCY DEPT. REPORTS
❒ PATHOLOGY
❒ TEST RESULTS (labs, radiology, EKGs, EEGs, Echo)
❒ OTHER _____
❒ ASSAULT RECORDS
❒ ALL OF THE ABOVE

ADDITIONAL DOCUMENT SET (comprised of Minimum Document Set, plus each of the following if selected):
❒ PHYSICIAN ORDERS
❒ PROGRESS NOTES
❒ NURSING NOTES
❒ GRAPHICS
❒ PHYSICAL THERAPY/ SOCIAL SERVICE NOTES
❒ NUTRITION SERVICES NOTES
❒ CONSENTS
❒ MEDICATION LISTS
❒ ANESTHESIA RECORDS/ OTHER SURGERY DOCUMENTS
❒ OTHER/MISC. _____

5. ACTIONS FOR STAFF TO TAKE

MAIL TO ORGANIZATION/ AGENCY	ATTN:

ADDRESS	CITY	STATE	ZIP

PHONE#

❑ Review Only (DATE AND TIME) _____
❑ DATE RECORDS WILL BE READY FOR PICK-UP _____
❑ VERBAL EXCHANGE

❑ FAX TO: Fax #

OhioHealth

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PATIENT IDENTIFICATION LABEL

AUTHORIZATION TO RELEASE INFORMATION

Chart Tab: CONSENT

6. MEDIA PUBLIC DISCLOSURE

For Marketing and Communications Use Only.

I AUTHORIZE THE PUBLIC DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW:

❑ name and age ❑ city of residence ❑ hospital admission, discharge or treated/released status

❑ brief extent of injuries or illness ❑ diagnosis, treatment, prognosis ❑ photographs, videotape or audiotape

❑ other (describe) _____

FOR THE PURPOSE OF: ❑ hospital produced publications/promotions/advertising ❑ hospital events/presentations/projects

❑ hospital web-site ❑ educational purposes/professional conferences ❑ all news media

❑ other use (describe) _____

7. AUTHORIZATION

Authorization and Expiration:

- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that treatment or payment of my claim will not be impacted by not signing this form. Research related treatment is strictly voluntary.
- I understand that by signing this authorization it gives the researcher(s) the permission to use or disclosure my personal health information for such research.
- I understand that my records/protected health information cannot be released unless I sign this form.
- As described in the notice of privacy practices of OhioHealth I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by OhioHealth in reliance on this authorization, by sending a written revocation to: (entity's) Medical Record Department, (entity's address.) Attn: Information Associate.

Riverside Health Center (614) 566-5000	Riverside Methodist Hospital (614) 566-5000	Grant Medical Center (614) 566-9000	Grady Memorial Hospital (740) 615-1030	Doctors Hospital (614) 544-1000	Doctors Hospital Nelsonville (740) 753-1931
Mcconnell Health Center (614) 566-5356	Dublin Methodist Hospital (614) 544-8000	Homereach (614) 566-0888	Marion General Hospital (740) 383-8400	Hardin Memorial Hospital (419) 673-0761	Neighborhood Care Health Center

I understand that this authorization may include information concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus),AIDS (Acquired Immunodeficiency syndrome), PSYCHIATRIC and/or DRUG/ALCOHOL TREATMENT that may be in my medical record.

8. EXPIRATION

This authorization for release of protected health information for the date of service indicated is effective until _____ or for a maximum of one year from the date signed below.

I hereby authorize _____ (name of entity) to disclose to the party (parties) named in this document, information from my medical record for the reasons and time specified.

X Signature of Patient _____ Date_____ Time _____

Signature of Individual Authorized by Patient _____ Date_____ Time _____

Relationship to Patient _____

9. REDISCLOSURE

Prohibition on Redisclosure: I understand this information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.

FEES

According to Ohio Revised Codes there is a per page fee for records. The fee will be dependent upon the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

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Chart Tab: CONSENT

PATIENT IDENTIFICATION LABEL