University of Cincinnati
Medical Center

Office of Administrative Services

Health Professions Building
Eden and Bethesda Avenues
Cincinnati, Ohio 45267-0553

February 22, 1994

UCCM / UCM1.950117.001

We have your request for information on the above named individual regarding the radiation studies conducted at General Hospital from 1960 through 1971. After a thorough investigation, it has been determined that your family member was not among those reported to the Department of Defense.

Unless we hear from you otherwise, no copies of medical records will be retrieved for your family member. If you wish to pursue obtaining copies of any medical records, the normal procedure should be followed as outlined in the attached document.

Identifying the participants has been a slow and difficult process. We regret the delay in responding to your request but we are sure you can appreciate the difficulty due to the number of requests, the age of the records and our desire to be as accurate as possible.

Sincerely,

Cyril W. Kupferberg
Chair of Radiation Response Team
Associate Senior Vice President

ROICOR

UMC-218. 4/92

UNIVERSITY OF CINCINNATI HOSPITAL

AUTHORIZATION FOR RELEASE OF INFORMATION

I the undersigned, hereby authorize _____ to release the following
HOSPITAL, AGENCY NAME
information from my (or give relationship _____) medical record. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficency Syndrome (AIDS), AIDS-Related Complex (ARC) and/or tests for antibodies to the AIDS virus (HIV). Review of the records is also authorized.

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative, Procedures
( ) History & Physical
( ) Consultation Report(s)
( ) Operative Report(s) & Findings
( ) Dates of Treatment _____ or Particular Illness (specify) _____

( ) Reports of Tests & X-Rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes (Specify)
( ) Clinic _____
( ) Immunization (Shot) Records
( ) Other

( ) In-patient ( ) Out-patient ( ) Emergency Dept.

The above information is to be forwarded to:

Name & Title of person _____

Agency/Hospital _____

Street Address _____

City, State & Zip Code _____

The above informaiton is requested to be released for the following purposes only.

_____

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by my choice, in which case the consent will expire on _____

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

Patient's Name _____ Signature (OF PATIENT) _____

Address _____ Witness _____

Birthdate _____ Record # _____ Date _____

*Patient is unable to sign because he/she is an unemancipated minor, _____

years of age, or for the following reason: _____

_____

_____ _____

Witness Closest Relative or Legal Guardian

_____

Relationship to Patient

UNIVERSITY OF CINCINNATI HOSPITAL
Medical Record Services

POLICY: *Guidelines for Releasing Medical Information of Deceased Patients*

The following guidelines are followed when releasing medical information for patients who have expired.

1. Please complete the attached Authorization for Release of Information form, providing all of the required information.

2. A valid authorization is required before any medical information can be released.

   a. An authorization is considered valid if it is signed and dated by the executor or administrator and the estate papers are attached to the authorization.

   b. The authorization may be signed by the next of kin if no estate exists. The appropriate next of kin is determined according to the following sequence:
      1) Spouse of deceased
      2) Adult children of deceased
      3) Brothers and/or sisters of deceased
      4) Grandchildren of deceased

   c. A death certificate is required if the patient did not expire at University Hospital and there are no estate papers

3. Please forward your request to:
   Medical Record Services - M.L. 0738
   University of Cincinnati Hospital
   Cincinnati, OH 45267-0738

4. The fee for copies of medical records is $0.75 per page ($1.00 per page for records on microfilm) plus a $17.50 retrieval fee, tax, shipping and handling.