Ohio Attorney General's Office
Bureau of Criminal Investigation
Investigative Report

2024-0109
Officer Involved Critical Incident - 9714 St Route 93, Pedro, OH 45659

Investigative Activity:	Medical Records Review
Involves:	Skylar Corbin (S)
Date of Activity:	01/24/2024
Author:	SA Matthew Collins, #151

Narrative:

On January 24, 2024, Ohio Bureau of Criminal Investigation (BCI) Special Agent Matt Collins (SA Collins) received a fax from MRO, who processes medical records requests for Cabell Hospital. SA Collins had previously requested a subpoena from the Lawrence County Prosecutor in regards to the medical records related to Skylar Corbin's treatment at Cabell Hospital. SA Collins, in error, did not realize the subpoena had not been domesticated prior to service. Understanding the declination, SA Collins contacted the Lawrence County Prosecutor's Office and requested a domesticated subpoena be obtained.

Attachments:

Attachment # 01: Declined_Cabell_MRO_1.24.24
Attachment # 02: Corbin_Cabell Hosp_Subp.1

Approved By SA James A. Mulford on
02/01/2024

FAX

Correspondence

TO:	Matthew Collins
ORGANIZATION:	Bureau of Criminal Investigation (BCI)
FAX NUMBER:	18777321134
DATE / TIME:	2024/01/24 0:58:01 EST
SUBJECT:	Issues
FROM:	Default OutboundFax
RETURN PHONE:	(610) 994-7500

MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

Phone: (610) 994-7500 Opt. 1
Fax: (610) 962-8421

Request ID: **78190064**
Tracking #: **CBHHDS7CPAEC2**

Track your request at: **www.roilog.com.**
Enter your Tracking # and Request ID.

Matthew Collins
Bureau of Criminal Investigation (BCI)
1560 State Route 56 SW
P.O. Box 365
London, OH 43140

Date: 1/19/2024
Phone: 216-218-2380
Fax: 877-732-1134

Notice of an Issue Regarding Your Medical Record Information Request

MRO works with your healthcare provider to process requests for copies of medical records on their behalf. As their business partner, it is our pleasure to serve you! Please note that there is an issue with your request (see detail at the bottom of the Notice) and we ask that you provide us with some additional information so that we can resolve the issue and fulfill your request. Please submit the additional information described in this Notice directly to MRO by mail, fax, or email. Once the issue is resolved, your request will be processed as quickly as possible.

Should you have any questions, please feel free to contact MRO directly regarding this request by dialing (610) 994-7500 Opt. 1 or by submitting an email to Requestinformation@mrocorp.com. To help us better assist you, please be sure to include your Request ID in the subject line of your email.

MRO is processing your request applicable to state & federal laws and regulations. Please notify the patient that the provision of treatment, payment, enrollment, or eligibility for benefits will not be conditioned on the elements of the authorization provided or your request for copies of the patient's records, unless permitted under 45 CFR 164.508(c)(2)(ii)(A)-(B).

Thank you,
MRO

Patient Name: **SKYLAR CORBIN**
Your Reference Number:

Your Request Date: 1/18/2024
Date Received at Facility: 1/18/2024

Your request is being processed by MRO on behalf of the following facility:

Cabell Huntington Hospital
1340 Hal Greer Boulevard
Huntington, WV 25701

ISSUE LIST
Out of State Subpoena The subpoena issued to the facility is from another state which has no jurisdiction. Please submit a domesticated or federal subpoena or an authorization signed by the patient.

CABELL HUNTINGTON HOSPITAL
1340 Hal Greer Blvd.
Huntington, WV 25701

Health Information Management
Phone Number: 304-526-2010
Fax Number: 304-526-2012
Radiology Film/CD
Fax Number: 304-399-2725

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name _____ DOB _____ SS# _____

Address _____

_____

SEND INFORMATION TO: (please be specific) _____

Name/Organization _____ Daytime phone _____

Address: _____ City, State, and Zip: _____

PURPOSE OF USE/DISCLOSURE: ☐ Further medical treatment ☐ personal use ☐ At the request of the patient

Other: (Specify) _____

FORMAT REQUESTED: ☐ Paper ☐ Electronic

SPECIFIC INFORMATION TO BE USED/DISCLOSED (INCLUDE DATES OF SERVICE IF POSSIBLE):

☐ Entire Record ☐ Other (specify) _____
*******May require specific dates of service for records prior to 2007*******

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐	HIV/AIDS Virus	_____ Signature
☐	Drug, Alcohol Abuse/Treatment	_____ Signature
☐	Protected Health Information on a minor	_____ Signature of Minor
☐	Psychiatric/Mental Health	_____ Signature

I authorize the use or disclosure of health information as specified above. I understand that authorizing the use or disclosure of this health information is voluntary and treatment, payment or other benefits may not be conditioned on the execution of this authorization. **I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.** I understand that I have a right to revoke this authorization at any time, providing the information has not already been used or disclosed. I understand I must do so in writing and present it to the Health Information Management Department at Cabell Huntington Hospital.
Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

_____ _____ _____
Signature of patient or Legal Representative Date Witness
Attach copy of legal documentation (i.e. POA, Executor)

MRO HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. **NO CHARGE APPLIES FOR RECORDS PROVIDED DIRECTLY TO A PHYSICAN. TO CHECK THE STATUS OF A REQUEST, PLEASE CONTACT MRO Requester Services at 610-994-7500 Option 1.**