Premier Health
Premier Physician Network

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

IMPORTANT—PLEASE NOTE: Charges for this request may apply. Allow up to 30 days for processing.

By completing this request and signing below, I hereby authorize the Health Information Management Services department of one or more affiliated entities of Premier Health, to release my protected health information to the following people or parties:

1. List below the name and address of person or organization to receive the information.

SEND TO (Enter Name and Address where medical records will be sent):

Name: _____

Street address: _____ City/State/Zip Code: _____

2. The purpose of this request is for: (please check one of more of the following)

____ Continuity of Care	____ SSI/Disability	____ Legal matter
____ Insurance Claim	____ Request of the Patient	____ Other (specify): _____

3. PATIENT NAME when treated (print):_____ Date of Birth: _____

Address:_____

Telephone Number(s):_____Last 4 digits SSN (optional):_____

4. RECORDS FROM (Enter Name of Physician/Provider or Medical Office where treated):

_____

5. Dates of Service to Release: _____

____ Office Visits	____ Laboratory reports	____ Pathology reports
____ Operative reports	____ Cardiac reports	
____ Immunization record	____ Radiology reports	____ Other records (specify): _____

6. I wish this information to be sent via:

____ **Secure email* at this email address:** _____

____ **Mailed to address listed in section 1** ____ **Other (specify):** _____

*Note: If sent through secure email you will receive a message in your inbox with a link to retrieve the encrypted data through ourcopy vendor's secure email portal

_____

I understand that the information I requested above and am authorizing for release MAY include information about testing, diagnosis, or treatment for physical or mental/psychiatric illness, drug/alcohol abuse, HIV/AIDS and related conditions, and assault. I understand that the information I am authorizing to be released may be redisclosed by the recipient and no longer protected by state or federal privacy regulations. The recipient of the information may be charged for the information released. There is no charge for releasing the information directly to my health care provider. I also understand that this authorization is completely voluntary and that I have the right to refuse to sign it. My refusal to sign the authorization or to release my information will have no effect on my ability to obtain treatment.

(over)

If my information contains federal drug and alcohol records, my records are protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, and a notice will accompany a disclosure.

This authorization will remain in effect for one year from the date of my signature, unless I specify an earlier date in this space_____. I further understand that this authorization may be withdrawn in writing at any time, (see Notice of Privacy Practices), but the withdrawal will not apply to information that has already been released in response to this authorization.

After my health information is released, the information may be re-released by the recipient and may no longer be protected by law.

Is patient able to make health care decisions for themselves? _____Yes _____ No

_____ _____ _____

Patient/Patient Personal Representative Signature** Printed Name Date Signed

_____

Relationship if not Patient

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*