PriMED PHYSICIANS
Treating You Well.®

Patient Authorization for Disclosure to Designated Provider

Please print all information, then sign and date form at bottom.

Patient Name	
Patient Social Security Number	**Patient DOB**

Purpose of request – I request and authorize the disclosure or release of protected health information (as identified below) to the following provider**:**

Provider Receiving Records	Provider Releasing Records
Name of practice	Name of practice
Name of provider	Name of provider
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone

Reason for request:

☐ **Continuity of Care** ☐ **Legal Matter** ☐ **Insurance** ☐ **Request of the individual**

☐ **Selecting new provider Are you requesting a permanent transfer from this office? Y N**

Description of information to be disclosed – I authorize the disclosure of the following protected health information about me to the person(s) identified above:

☐ Complete medical record of last two years patient was seen **OR**
☐ Only the following information**:**

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There is no charge for the first duplication of a patient's medical record. Additional requests will be subject to fees in accordance with the Ohio Revised Code 3701.741. Additional requests for records on a flash drive are $10 ($15 if sent Certified Mail) and not to exceed $50 for paper copies (not including postage).

- **Expirations or termination of authorization:** This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.
- **Right to revoke or terminate:** As stated in our Notice Privacy Practices, you have the right to revoke or terminate this authorization. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.
- **Redisclosure:** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.
- **No conditions:** Your signature on this authorization does not condition your treatment, payment or eligibility for benefits.

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Patient or Responsible Party Signature Date