PriMED PHYSICIANS
Treating You Well.®

Authorization to Release Protected Health Information (PHI)

Patient Name: _____ Maiden Name: _____

SS #: _____ Date of Birth: _____

Home Phone: _____ Cell/Work: _____

Address: _____ City/State/Zip: _____

Email Address: _____

A) I hereby authorize records FROM:

Name-Practice: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

B) To be released TO:

Name-Practice: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

C) For the purpose of:

- ❑ Litigation
- ❑ Insurance
- ❑ Self/Personal Copy
- ❑ Continuity of Care
- ❑ Disability/SSI
- ❑ Work Comp
- ❑ Other
- ❑ **Transfer of Care (Permanently Leaving)**

Date Range:
_____ to _____

- ❑ Physician Office Notes
- ❑ Immunizations
- ❑ Operative/Procedure Reports
- ❑ Other _____
- ❑ Cardiology/EKG Reports
- ❑ Lab/Path Reports
- ❑ Radiology/X-ray/MRI Reports
- ❑ Last two years patient was seen

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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 confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Date Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date: _____
Expiration date of authorization

Please complete this form and return it to PriMED Health Information Department, 6520 Acro Court, Suite 103, Centerville, OH 45459 or fax to 937-291-6942.