Premier Health
Upper Valley Professional Corporation

Authorization for Release of Medical Information

_____
Print Patient's Full Name

_____
Patient's Date of Birth

_____
Social Security Number

Records to be released to:

_____

_____

_____

Records to be released from:

☐ After Hours Family Care
☐ Troy Primary Care Physicians
☐ Hyatt Family Care
☐ Pediatric Group
☐ Stanfield Family Care
☐ Stillwater Family Care
☐ Covington Family Care
☐ Premier Family Care of Piqua
☐ Upper Valley Women's Center
☐ Miami County Surgeons
☐ Upper Valley Cardiology
☐ Upper Valley Orthopaedics

I authorize release of information for the following reason(s):

___ Consult/Second Opinion ___ Relocating Out of Town ___ Change of Insurance ___ Specialist Care
___ Selecting new physician ___ Other (specify) Comments:_____
_____

Information requested: (May include treatment or rehabilitation of drug and/or alcohol abuse or psychiatric treatment if they did occur)

☐ Admission Record (Facesheet)
☐ Discharge Summary
☐ History & Physical
☐ Cardiopulmonary Reports
☐ Cardiac Cath Films
☐ After Hours/Urgent Care
☐ Consultations
☐ Physician Orders
☐ X-Ray/Imaging Reports
☐ X-Ray/Imaging Films
☐ Psychological Evaluation
☐ HIV
☐ Progress Notes
☐ Operative Reports
☐ Laboratory Reports
☐ Laboratory Slides
☐ Drug Alcohol History
☐ Other _____

Requested Method of Disclosure:

☐ Mail ☐ Fax - fax number _____ ☐ Patient will pick up records on:_____

☐ Inspect the records requested ☐ Inspect and provide copy of requested records

☐ Summary of records requested ☐ Summary and complete copy of records

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This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by Ohio Administrative Code 3793:2-1-06 (Alcohol and Drug Addiction Medical Records); Ohio Revised Code 5122.31; Ohio Administrative code 5122-14-22 (Psychiatric/Mental Health Records), Ohio Revised Code 3701.243; Ohio Administrative Code 3901-1-49 (Confidentiality of HIV/AIDS Related Information). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as other permitted by 42 C.F.R., Part 2. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug client.

I understand that I have no obligation whatsoever to disclose information from my record and understand that I may revoke this authorization at any time, in writing, except to the extent that action based on this consent has been taken. 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 sixty (60) days. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated.

Revised 9/4/13

I understand that I have the option to request records in summary form in lieu of or in addition to the requested information. I further agree that the Corporation, or its' agent, may charge me for any designated costs incurred in preparing the copy or summary of the requested medical records in accordance with state and federal guidelines.

We are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- Your access request form is not signed by you or your representative;
- Your access request form is signed by your representative and the representative has not provided information on the source of his/her authority to act for you.
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of your records;
- Your request is for psychotherapy notes;
- Your request includes information compiled for litigation;
- Your request includes information held by our laboratory that is not accessible by law;
- Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information);
- Your request relates to certain information that was obtained from confidential source and we are not required to provide access to it by law.

MY SIGNATURE BELOW AUTHORIZES RELEASE OF ALL INFORMATION REQUESTED ABOVE.

_____	_____	_____
Print Patient's Full Name	Signature of Patient	Date

_____	_____
Signature of Responsible Party/Relationship	Date

_____	_____
Signature of Witness	Date

I have read the **REQUIREMENTS FOR OBTAINING ORIGINAL IMAGING FILMS/PROCEDURES** and hereby state that I understand these requirements and have complied or will comply with each one set forth therein. I further understand that by taking possession of X-rays Films I will be responsible to insure its/their safekeeping and will return it/them to _____ on or before _____ in its/their original condition. _____ (Initial) OR ☐ N/A

This portion is to be completed when a patient is unable to give written consent.

We, the undersigned, do verify the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of information.

Verbal consent requires two witness signatures

_____	_____
Signature of Witness/Relationship to Patient	Date
_____	_____
Signature of Witness/Relationship to Patient	Date

FOR OFFICE USE ONLY:

☐ Mailed/Faxed to requester on: _____ ☐ Patient will pick up records on: _____ ☐ Picture ID Validated