Premier Health

Atrium Medical Center
Health Information
Management Services
P.O. Box 8810
Middletown, OH 45042
(513) 974-5200

Miami Valley Hospital
Health Information
Management Services
One Wyoming St.
Dayton, OH 45409
(937) 208-3060

Upper Valley Medical Center
Health Information
Management Services
3130 N. County Rd., 25A
Troy, OH 45373
(937) 440-4650

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

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

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: (**please list below the name and address of person to receive the information**.)

Release To: _____ Address:_____

_____

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

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

Patient Name when Treated (printed):_____ Date of Birth: _____
Address:_____
Telephone Number(s):_____ Last 4 digits SSN (optional):_____
Location of Treatment (circle): **Atrium Medical Center** **Good Samaritan Hospital** **Miami Valley Hospital**
Upper Valley Medical Center **Samaritan Behavioral Health** **Fidelity Health Care** (MVH Main, MVH North, MVH South)
Premier Physician Office (specify): _____ **Other**:_____

Dates of Service to Release: _____

____ Office Visits ____ History & Physical ____ Physical/Occupational Therapy reports
____ Emergency Department reports ____ Cardiac reports ____ Homecare records
____ Discharge Summary ____ Laboratory reports ____ Radiation Oncology records
____ Operative reports ____ Radiology reports ____ Pathology reports
____ Complete record
____ Other records (please specify): _____

I wish this information to be sent via:

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

____ **flash/thumb drive** mailed to my home ____ **CD** mailed to my home ____ other: _____

*(Note: If sent through secure email you will receive a message in your inbox with a link to retrieve the encrypted data through our secure email portal https://www.uapguide.com/premier-health-partners/employee/recipient-experience)

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.*