PREMIER HEALTH USE ONLY: This Section completed by Premier Health personnel.	
☐ Request Approved	
☐ Request Denied (Complete Patient Access Denial Form)	
☐ NA (Information released to persons other than the patient)	
Date: **Initials:**	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/PATIENT ACCESS FORM

Patient's Name: _____ Unit #: not applicable Acct #: not applicable

Birth Date: _____ Social Security Number: _____

Service Date/Type(s): not applicable
(Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize (*insert name of physician/practice*)_____ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

INFORMATION REQUESTED

☐ Face Sheet	☐ Progress Notes	☐ X-ray Reports	☐ Pathology Reports / materials
☐ History / Physical	☐ Physician Orders	☐ Consultation(s)	☐ Operative Reports
☐ Discharge Summary	☐ EKG Interpretations	☐ Laboratory Reports	☐ Copy of Entire Record

☒ Other - Please Specify: ***Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely***

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: ***60 days from date of signature below***. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

This information is to be released for the purpose of: ☐ At the request of the patient **OR** ☒ Other (Please specify below):
To meet hospital Infection Control Guidelines (immunity to rubella) and any limitations for the safety of the volunteer, patients and visitors

I understand that I may revoke this authorization in writing at any time, except if Premier Health has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Premier Health will not condition the provision of treatment or payment to me on the signing of this authorization, except that Premier Health may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Premier Health may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

Signature of patient or representative: _____ **Date:** _____

***If you are the representative of the patient**, describe the scope of your authority to act on the patient's behalf. Please check one below:*

☐ Guardian ☐ Parent of Minor ☐ Power of Attorney Over Healthcare

*This authorization will be accepted up to **60 days** from date of signature.*

Signature of witness: _____

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations

A photocopy of this authorization is to be accepted the same as the original.