Premier Health
Fidelity Health Care

Authorization for Release of Medical Information

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

From: _____ To: _____
_____ _____
_____ _____
_____ _____

I authorize this release of information to either ☐ **verify services rendered to process a claim for benefits**, ☐ **to provide continuity to my medical care**, ☐ **at the request of the individual**, ☐ **other** _____.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for one year from the date of my signature below unless I specify an earlier expiration date in this space _____. I understand also, that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification to the parties involved (see Notice of Privacy Practices).

It is my desire that only the information in my ☐ inpatient record, ☐ clinic record, ☐ emergency record, ☐ ambulatory testing (please check the appropriate boxes) indicated below is to be released as a result of this authorization:

☐ Face Sheet	☐ Laboratory Reports	☐ Therapy Reports
☐ History & Physical	☐ Operative Reports	☐ Emergency Treatment
☐ Discharge Summary	☐ Pathology Reports	☐ Other specified here:
☐ Consultation Reports	☐ Physician Progress Notes	_____
☐ Radiology Reports	☐ Physician Orders	_____

I am also making the following additional qualification: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

To assist you, I am providing the following additional identifying information:

_____ _____
(Name When Treated) **(Street Address)**

_____ _____
(Date of Birth) **(City)** **(State)** **(Zip)**

_____ _____
(Social Security #) **(Dates of Treatment)**

Reason patient is unable to sign: _____

_____ _____ _____
(Date) **(Patient or Guardian Signature)** **(Witness)**

☐ HCPOA ☐ Executor ☐ Guardianship forms received