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 Release of Medical Information

IMPORTANT-PLEASE READ:

Charges for this request may apply. Allow up to 30 days for processing. **MEDICAL RECORD # _____**
All requests will be mailed unless other arrangements are specified.

I hereby grant permission for release or review of the following information relating to my care from the following hospital (or its agent) to the parties named herein.

FROM: _____ **TO:** _____
_____ _____
_____ _____
_____ _____

The purpose of this request is for:
☐Continuity of Care ☐Legal matter ☐SSI/Disability
☐Insurance claim ☐At the request of the individual ☐Other (specify) _____

_____ _____
Patient's Name Date of Birth

_____ _____
Name at time of treatment Social Security Number

_____ _____
Patient's Address Telephone Number

Date of treatment(s)_____
This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur, I specify that this release to include:

☐ Facesheet	☐ Laboratory Reports	☐ Mental Health Treatment
☐ Discharge Summary	☐ Radiological Reports	☐ Other specified here:
☐ History & Physical	☐ Operative Reports	_____
☐ Consultation	☐ Progress Notes	_____
☐ Emergency Room Treatment	☐ Pathology Reports	_____
☐ Physician Orders	☐ Drug/ Alcohol Abuse Treatments	_____

I understand that the information I authorize a person or entity to receive may be re-disclosed 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 I understand that this authorization may be withdrawn at any time in writing (see Notice of Privacy). This authorization will be in effect for one year after sign and date the form below unless I specify an earlier expiration date in this space _____.

_____ _____ _____ _____
Date Signature Witness Date

☐HCPOA ☐Executor ☐Guardianship forms received

Is patient unable to make healthcare decisions for herself/himself? ☐ Yes ☐ No

If the above signature is not that of the patient, explanation will be provided below and documentary evidence of appropriate papers shall be required to accompany this authorization _____
_____