Premier Health
Premier Physician Network

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:

Records from _____

_____

_____

Send to _____
(Physician Name if applicable)

_____

_____

I authorize this release of information for the following reason:

❑ Consult/Second Opinion ❑ Relocating Out of Town ❑ Specialist Care ❑ Change of Insurance

❑ Selecting New Physician *(not for insurance reasons)* ❑ Other (specify) _____

I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific written authorization. However I understand that the person or entity receiving my information may not be subject to any Federal privacy regulatitons. I understand that this authorization is voluntary and that I may refuse to sign it; my refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space _____. I understand that, except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.

It is my desire that only the following information indicated below be released as a result of this authorization:

❑ Any and all records from all sources in our possession (specify dates of treatment _____)

❑ Complete Chart ❑ Laboratory Results ❑ Radiology Reports

❑ Demographic Sheet ❑ Operative Reports ❑ Therapy Reports

❑ History and Physical ❑ Pathology Reports ❑ Medications Prescribed

❑ Consult Reports ❑ Progress Notes ❑ Record of Center (specify dates of treatment _____)

❑ Immunization Record ❑ Emergency Room ❑ Other (specify) _____

I am also making the following additional qualifcation: **IF** the information specified above contain information related to treatment for drug and/or alcohol abuse, 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.

_____ _____ _____
Date Patient/Parent or Guardian Signature Witness

To assist you, I am providing additional identifying information:

_____ _____
Print Name When Treated Street Address

_____ _____ _____
Telephone Number Date of Birth City, State, Zip Code

_____ _____
Social Security Number (last 4 digits only) - Optional Dates of Treatment

State reason if patient is unable to sign _____

Records to be ❑ Mailed ❑ Faxed ❑ Picked up ❑ Electronic ❑ Other, as requested

Date Completed _____ By _____