Premier HealthNet
Premier Health Partners

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 regulations. 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 & Physical _____ Pathology Reports _____ Immunization record
_____ Medications Prescribed _____ Consults Reports _____ Other (specify)
_____ Emergency Room _____ Progress Notes _____
_____ Record of center only (*specify date of treatment*: _____,

I am also making the following additional qualification: **IF** the information specified above contains 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 or Guardian signature Witness

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

_____ _____
Print name when treated Street Address

_____ _____
Phone # Date of birth City State Zip code

_____ _____
Social security # (last 4 digits only) - OPTIONAL Dates of treatment

State reason if patient is unable to sign: _____

Records to be: ☐ Mailed ☐ Faxed ☐ Picked up

Date completed: _____ By: _____