Premier HealthNet
Samaritan Family Care, Inc. and MVHE, Inc.
And Health Specialists of Dayton, Inc.

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 ____, 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. 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.

I am also releasing information specified above containing 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.

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

Complete Chart _____	Laboratory Results _____	Radiology Reports _____
Demographic Sheet _____	Operative Reports _____	Therapy Reports _____
History & Physical	Pathology Reports _____	Medications Prescribed _____
Consult Reports _____	ER Progress Notes _____	Other (specify) _____

_____ _____ _____
Date Patient/Parent or Guardian Signature Witness

_____ _____
Print Name when Treated Street Address

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

_____ _____
Social Security Number Dates of Treatment

State reason if patient is unable to sign: _____

Records to be: Mailed _____ Faxed _____ Picked up _____ Date Completed _____ By: _____