Submit Record Request to:
Primary Health Solutions - Medical Records
300 High Street - 3rd Floor
Hamilton, Ohio 45011
Office: 513-454-1115
Fax: 513-737-1592

Medical Records Release
Authorization for Use and Disclosure of Protected Health Information (PHI)

This Authorization is according to federal Privacy Laws.

Patient Information: (PLEASE PRINT)

Last Name: First: Middle: .

Date of Birth: SSN: .

Phone: Email: .

Address: .

City: State: Zip: .

I, the above identified person, do hereby authorize the release of my PHI as indicated (Identify individual/group/entity and list address):

From: .

To (Name/Provider/Practice): .

Address: City: State: .

Phone: Fax: .

I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse. I understand that if the person/entity that receives my Protected health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purpose or unless the provision of treatment is related solely to the disclosure of my PHI to third party such as when requested by my employer.

Protected Health Information (PHI) to be used or disclosed (Check box or boxes):

- □ Office Visits/History and Physical Exam
- □ Lab Reports
- □ PHS Consultation Reports
- □ Radiology/Diagnostic Reports
- □ Other _____

This authorization covers the following time period of healthcare, From: _____ To: _____

This information is being disclosed for the following purpose:

- □ Changing Physicians
- □ Continuing Care
- □ Patient Request
- □ Worker's Compensation
- □ Second Opinion
- □ Legal
- □ Insurance
- □ School
- □ Disability
- □ Other: _____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to Medical Records at 300 High Street, 4th Floor, Hamilton, OH 45011.

This authorization will expire in 60 days, unless otherwise specified: _____

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms:

Patients Signature: _____ Date: ___/___/___

- YOU SHOULD RECEIVE A COPY OF THIS AUTHORIZATION FORM AFTER SIGNING -

If you are signing as a legal representative for an individual, read and sign below:

I, _____hereby certify and attest that I am the duly authorized legal representative of _____and that I have the lawful authority regarding use and/or disclosure of Protected Health Information of such individuals for the purposes set forth in this document.

Signature: _____ Date: ___/___/___

FOR STAFF USE ONLY

Date request received: ___/___/___ Staff Signature: _____ □ Identification Verified