Primary Health Solutions School-Linked Services with Northridge Schools

PLEASE SEND COMPLETED FORM TO: medicalrecords@myprimaryhealthsolutions.org, with the subject line: Northridge ROI

Medical Records Release

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

This Authorization is according to federal Privacy Laws.

Student / Patient Information: (PLEASE PRINT)

Last Name: First: Middle:

Date of Birth: SSN:

Phone: Email:

Address:

City: State: Zip:

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

TO: Primary Health Solutions, 300 High Street, 4th Floor, Hamilton, OH 45011

FROM: South Community, 3095 Kettering Blvd, Moraine, OH 45439

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: Complete Record

This authorization covers the following time period of healthcare,

From: **all** To: **all**

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.

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

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.

Parent/Guardian Signature: _____ Date: ___/___/____

FOR STAFF USE ONLY

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