Primary Health Solutions

Medical Records Release

Authorization for Disclosure of Protected Health Information (PHI)

***Request will be invalid if form is not completely filled out.**

Patient Information *(Please Print)*

Patient Name	Date of Birth	Social Security #
Phone	Email	
Address		

***If this section is not completed, records will be sent to the patient.**

Obtain Records From: *I authorize the below Health Care Provider to release my/the patient's individually identifiable health information as described below.*	**Send records to:** *I authorize the Health Care Provider to release the information described in this release to:* ☐ **SELF**
Name/Agency	Name/Agency
Address	Address
City/State/Zip	City/State/Zip
Phone	Phone
Fax	Fax
Secure Email	Secure Email

Date Range for Requested Records: From _____ To _____.

Medical Information Requested (Check all that apply)

☐ Office Notes ☐ PHS Consultation Reports ☐ Lab Reports ☐ Billing Records

☐ Radiology/Diagnostic Reports ☐ Immunization Records ☐ Dental Records ☐ Complete Medical Record

☐ Other: _____

Purpose of Request:

☐ Changing Providers ☐ Continuing Care ☐ Patient Request ☐ Worker's Comp ☐ Second Opinion

☐ Legal ☐ Insurance ☐ School ☐ Disability ☐ Other: _____

Preferred Delivery: ☐ Paper Copy ☐ Flash Drive ☐ Email* ☐ Fax ☐ Patient Portal/Intelichart

**By providing Primary Health Solutions with my email address, I understand and accept the risks involved with the transmission of my medical documentation. Due to size limitations, records may be mailed.*

My Highly Confidential Information

By initialing below, I give permission for that specific information to be used and/or shared as described in this authorization.

_____ Mental Health Treatment _____ Sexually Transmitted Infections _____ Substance Abuse

_____ Infectious Disease (ex. Hepatitis) _____ Information about Genetic Testing _____ HIV/AIDS Testing/Treatment

Submit Records Requests to:

Primary Health Solutions – Medical Records

PO Box 837 | Hamilton, OH | 45012

Fax: (513) 737-1592 | **Phone:** (513) 869-4192

Email: medicalrecords@myprimaryhealthsolutions.org

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Authorization to Release

- I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked.
- I understand that this release is valid for one year from the day it was signed or on _____, and I may refuse to sign this authorization or revoke this authorization at any time. If I revoke or don't sign, it will not stop me from being seen at Primary Health Solutions.
- The revocation will take effect on the day a notification is received by Primary Health Solutions in writing to the attention of Medical Records Department from the patient and/or legal representative at the mailing address listed on the bottom of this page.
- I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received the revocation letter.
- I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that the information may be sent again and no longer protected.
- Requests will be completed within 30 days of the receipt of this authorization. Primary Health Solutions, Medical Records Department will communicate with the requestor if any part of the request cannot be completed.
- Your identification may be required to protect your privacy.

I hereby certify that I have read and understand the information provided within this authorization. I understand and agree to its terms.

Patient Signature: _____ **Date:** _____

Signature of Representative: _____ **Date:** _____

Representative Name (Please Print): _____

Authority to represent individual: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

Staff Use Only

Witness (Staff) Signature: _____ **Date:** _____

- **Identity Verified:** ☐ ID Provided
- **Representative Validated** (if applicable)**:** ☐ Documented in Chart
- **Patient MRN:** _____
- **Date Indexed in Patient Chart:** _____/_____/_____

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