Yellow Springs Primary Care
888 Dayton St., Suite 106
Yellow Springs, OH 45387
Office (937) 767-1088
Fax (937) 767-1022

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

Please Note : Copy fee may be charged for Medical Records

Patient's Name: ____ **Date of Birth:** ____________ **Account #** ______________
Last First Middle (MM/DD/YYY) *Office use only*

Address: ____
Street City State Zip

Phone Number: ____________________ **E-Mail Address:** ______________________ **Date(s) of Service:** ______________________

Purpose of Release:
- ☐ **Continuity of Care/ Treatment**
- ☐ **Leaving Practice/Change of Doctor (minimum document set)**
- ☐ **Self/Personal Reasons (minimum document set)**
- ☐ **Disability (minimum document set)**
- ☐ **Insurance**
- ☐ **Employment Related**
- ☐ **Research**
- ☐ **Legal Reasons**
- ☐ **Other (please specify):** ____

Person/Physician Practice/Organization Authorized to **Release** Information:

Yellow Springs Primary Care
Attention: Medical Records
888 Dayton St. Suite 106
Yellow Springs, OH 45387
Office (937) 767-1088 Fax (937) 767-1022

Physician Practice/Organization Authorized to **Receive** Information:

Name: ____

Address: ____

City, State & Zip: ___________________________________

Phone #: ________________ **Fax #:** ____________________

Information to be Released – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

☐ **Complete Record**

☐ **Minimum Documents (the following will be sent)**
- Progress Notes – last 2 years
- Radiology (if applicable) – last 2 years
- Lab (if applicable) –last 2 years
- Other Diagnostic Tests (if applicable)-last 2yrs
- Cardiovascular (if applicable) – last 2 years
- Consultations – last 2 years
- Hospital Records – last 2 years

☐ **Additional Documents** (comprised of Minimum Documents plus the following selected items):
- ☐ **Physician Orders**
- ☐ **Nurses Notes**
- ☐ **Medication Lists**
- ☐ **Drug Screens**
- ☐ **Other/Misc:** ______________________

Method of Release:
☐ **Mail** ☐ **Fax** ☐ **Other (please specify):** ____

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until ______________ or for a maximum of one year from the date signed below.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that YSPC has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the Yellow Springs Primary Care 888 Dayton St. Suite 106, Yellow Springs, Ohio 45387.

Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Fees: According to Ohio Revised Code, there is a fee for records. This fee will vary based on the entity requesting the copies and number of pages requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

I hereby authorize YSPC to release the health information indicated above that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses. My signature authorizes the release of such information. I understand that if this information is disclosed to a third party the information may no longer be protected by state and/or federal regulations. I release YSPC, it's employees, and agents from any legal responsibility and liability for the disclosure of the above information to the extent indicated and authorized herein.

____ ______________________
Signature of Patient **Date**

______________________________ ____________________ ______________________
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).