YELLOW SPRINGS PRIMARY CARE
888 DAYTON ST., SUITE 106
YELLOW SPRINGS, OH 45387
OFFICE (937) 767-1088

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

Patient's Name: _____ **Date of Birth:** _____
Last **First** **MI** **(MM/DD/YYY)**

Address: _____
Street **City** **State** **Zip**

Phone Number: _____ **E-Mail Address:** _____

Date(s) of Service: _____

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

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

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

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

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

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):
- □ **P**hysician Orders/Nurses Notes
- □ Medication Lists
- □ Substance Abuse Treatments/Drug Screens
- □ HIV/Aids Treatment
- □ Mental Health Treatment
- □ **Other/Misc:** _____

Method of Release: Please mail records to the above listed above. Documents can be sent in the form of paper, CD, or removable jump drive.

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.

I hereby authorize the above indicated party 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 also understand that the practice will not condition or deny any treatment based on my signing this authorization.

_____ _____
Patient Signature **Date**

_____ _____ _____
Patient's Legal Representative (if different from patient) **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).

_____ _____
Witness Signature **Date**