Prime Health
MEDICAL CENTER

Authorization to Release Protected Health information

PHMC staff members are available to help you if you have any questions about this form

By signing this form:

- I release Prime Health Medical Center (PHMC), its employees, officers, nurse practitioners, phyiscian assistants, and physicians from any legal responsibility or liability for disclosure of the information identified for release.
- I understand that once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not then be protected by federal & state privacy regulations.
- I may revoke this Authorization at any time by providing a written statement to the Health Information Management Dept., except to the extent that PHMC or other organization has already completed action on it.

Patient's Name: _____ Other names used: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Soc. Sec. #: _____ Phone #: _____

Facility to Release Records:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Facility/Person to Receive Records:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Information to be released at the request of the individual:

☐Chart Notes *(Within the last year only)*
☐Laboratory Results *(Within the last year only)*
☐Immunizations Records
☐Radiology / EKG Reports *(All available)*
☐Prenatal Care (Antepartum Care, Delivery, etc.)
☐Verbal Communication (detailed voicemails)
☐Other: _____
Date of Services: _____

Your initials are required for each to release the following information:

_____AIDS/HIV Information
_____Behavioral/Mental Health Information
_____Substance Abuse Information (See Back)
_____Genetic Information
_____STI Information

Purpose for Release:

☐Continued Patient Care ☐Personal Use ☐Attorney / Legal ☐Insurance ☐ Other: _____

Who should sign this form:

- If the patient is 18 years old or older, the patient must sign.
- If the patient is 18 years old or older but unable to sign, a Legal Guardian (as granted by court order) or Health Care Agent (as granted by a Health Care Power of Attorney) may sign. Please check your relationship:
  ☐Legal Guardian ☐ Health Care Agent
- If the patient is 17 years old or younger, the patient's parent, managing conservator, or legal guardian must sign, unless not required by state or federal law. Please check your relationship:
  ☐Parent ☐Managing Conservator ☐Legal Guardian ☐Other

Signature (required)	**Date (required)**
Printed Name of Person Signing (if not patient)	
This consent will expire one year from the date of signature or _____ (date, event, or condition)	

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Substance Use Disorder Patient Records Release

PHMC staff members are available to help you if you have any questions about this form

Description of Substance Use Disorder Information that may be Disclosed:

1. How much *(for example date range)*: _____

   What kind *(for example diagnosis)*: _____

2. How much *(for example date range)*: _____

   What kind *(for example diagnosis)*: _____

3. How much *(for example date range)*: _____

   What kind *(for example diagnosis)*: _____

Notice to Recipient: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.

Who should sign this form:

- The patient, even if a minor, must sign.
- EXCEPTIONS:
  - If a court finds that a patient lacks the capacity to handle their own affairs, consent may be given by a Legal Guardian (as granted by a court order) or Health Care Agent (as granted by a Health Care Power of Attorney). If the patient has a medical condition that prevents knowing or effective action on their own behalf, the director (CEO) may consent. Please check your relationship:
    ☐ Legal Guardian ☐ Health Care Agent ☐ Director
  - If the patient is deceased and the disclosure is for any other purpose other than to Vital Statistics, consent may be given by the executor, administrator, or other personal representative appointed under applicable state law. If there is no such appointment, consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family. Please check your relationship:
    ☐Executor ☐Administrator ☐Other Personal Representative ☐Other

Signature (required)	**Date (required)**

Printed Name of Person Signing

This consent will expire one year from the date of signature or _____ (date, event, or condition)