Authorization to Transfer Records
Providence Medical Group
2912 Springboro W, Suite 201
Dayton, Ohio 45439

Phone (937)297-8999 • Fax (937) 298-9673

I, the below identified person, do hereby authorize the release of my medical records, as indicated herein, between the following parties:

Records From: _____ **Send To:** _____
_____ _____
_____ _____

Send records electronically by secure email: _____

I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific authorization. However, I understand that the person or entity receiving my information may not be subject to any Federal privacy regulations. I understand that this Authorization is voluntary and that I may refuse to sign it; my refusal to sign will not affect my ability to obtain treatment. I understand that this Authorization shall remain in effect for sixty (60) days from the date of my signature unless I specify an earlier expiration date in this space_____. I understand that, except to the extent that action has been taken based on my authorization, I may withdraw this Authorization at any time by written notification to the parties involved. This Authorization in no way negates the ability of the above named practice to carry out any communication that may be necessary for patient continuity of care with another provider; nor does it replace the Providence Medical Group HIPAA Form (Patient Consent For Use And Disclosure of Protected Health Information).

Patient Name: _____

Date of Birth: _____ **Last 4 digits of Social Security:** _____

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

Phone: _____

It is my desire that only the following information indicated below be released as a result of this authorization:

_____ Copy of Record from _____ to _____

_____	Face Sheet/Demographics	_____	Operative Report
_____	History and Physical	_____	Consultation(s)
_____	Discharge Summary	_____	Progress Notes
_____	Lab/Pathology	_____	Emergency Dept. Records
_____	Radiology Reports	Other (please specify) _____	
		_____	Copy of Entire Record

I understand that this consent is to include disclosure of: (PLEASE INITIAL EACH)

_____ **Alcohol/drug abuse** _____ **Psychiatric Records**

_____ **Sexually Transmitted Disease Information** _____ **HIV/AIDS Information**

I understand that unless I specify a timeframe, 2 years of my past medical history will be sent to the designee. Initial here: _____

Reason for Record Transfer: (Please select one)

_____ **PMG Physician Referral to Specialist** _____ **Patient Request (personal use)**

_____ **Selecting New Physician** _____ **Third Party Request (i.e., Attorney, Insurance, etc.)**

_____ **Other - Please specify:** _____

***Please be advised: You may incur charges for your Medical Record Request. Please see our website for more information at** http://www.provmedgroup.com/medicalrecords.html**. For questions regarding Medical Records contact Providence Medical Group Administration at (937)297-4874.**

****ATTENTION NEW PATIENTS OF PROVIDENCE MEDICAL GROUP****NEW PATIENT MEDICAL RECORDS MUST BE FAXED TO 937-298-9673. PROVIDENCE MEDICAL GROUP NO LONGER ACCEPTS NEW PATIENT RECORDS ON FLASH/USB DRIVES.**

I hereby state that I have read and fully understand the above statements as they apply to the named patient. I hereby consent to the release of medical information. **Any further disclosure of this information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as permitted by law.** A photocopy of this Authorization is to be accepted the same as the original.

Signature of Patient/Guardian: _____ Date: _____

Witness: _____ **Date:** _____

****Please allow 30 days for processing your record(s) request****