



**Premier Family Physicians  
Authorization for Release of Patient Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number(s) w = work, h= home c= cell \_\_\_\_\_

**Request Records from: Please provide Name of Doctor/ Organization, Address, Phone and Fax Numbers:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Description of Information to be released: (please check all that apply)**

Immunization records     Laboratory Reports     Radiology/ Imaging Reports     Entire Record  
 Consultation     Progress Notes     Most recent history and physical  
 Other \_\_\_\_\_

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

**This above information is to be disclosed to:**

**Provider: \_\_\_\_\_  
Premier Family Physicians  
5625 Eiger Road, Suite 200, Austin, TX 78735  
Telephone: 512.892.7076, Fax: 512.899.8460**

**Description or the purpose of the use and/or disclosure:**

Continuing Care     Second Opinion     Social Security/ Disability     Personal Use  
 Consultation/ Referral     Insurance     Legal purposes  
 Other; Please describe \_\_\_\_\_

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Premier Family Physicians has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until \_\_\_\_\_ (date of event).

I understand I may revoke this authorization at any time by notifying Mary Rivera, custodian of Medical Records at Premier Family Physicians. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
Signature of Patient or Patient's Representative    Date    Printed name of Patient or Patient's Representative

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