



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 (Be sure to complete this section to prevent delays in obtaining your records):

Name of Doctor/Organization: \_\_\_\_\_ Phone:( ) \_\_\_\_\_ Fax:( ) \_\_\_\_\_

Address: \_\_\_\_\_
\_\_\_\_\_

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

- Entire Record Immunization Records Laboratory Reports Radiology/ Imaging Reports
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 (Please circle one):

Table with 5 columns: SW Medical Village, Westlake, Bee Cave, Dripping Springs, Premier Internists. Each column contains address, city, state, zip, and phone/fax numbers.

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 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.

X Signature of Patient or Patient's Representative Date Printed name of Patient or Patient's Representative