PREMIER FAMILY PHYSICIANS

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):

SW Medical Village	**Westlake**	**Bee Cave**	**Dripping Springs**
5625 Eiger Road,	**912 S Capital of Texas Hwy,**	**12600 Hill Country Blvd,**	**170 Benney Ln,**
Ste 200	**Ste 100**	**Ste R-103**	**Ste 200**
Austin, TX 78735	**Austin, Texas 78746**	**Austin, Texas 78738**	**Dripping Springs, TX 78620**
Fax: 512.899.8460	**Fax: 512.899.8460**	**Fax: 512.899.8460**	**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 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**