PREMIER FAMILY PHYSICIANS

Premier Family Physicians (PFP)

Authorization for Release of Patient Information

Patient Name _____**Date of Birth**_____

_____

Address **City** **State** **Zip**

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

How would you like to receive your records? ☐Mail ☐email(provide email address)_____

This following information is to be released from (Please circle one):

PFP SW Medical Village	**PFP Westlake**	**PFP Bee Cave**	**PFP Dripping Springs**	**Premier Internists**
5625 Eiger Road,	**912 S Capital of Texas Hwy**	**12600 Hill Country Blvd**	**104 W Mercer St.,**	**4534 Westgate Blvd.,**
Ste 200,	**Ste 100**	**Ste R-103**	**Ste H**	**Ste 108**
Austin, TX 78735	**Austin, Texas 78746**	**Austin, Texas 78738**	**Dripping Springs, TX 78620**	**Austin, TX 78745**
Fax: 512.899.8460	**Fax: 512.899.8460**	**Fax: 512.899.8460**	**Fax: 512.899.8460**	**Fax: 512.899.8460**

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

____Immunization record ____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 (Doctor Name)_____ **FAX#_(____)**_____

Address:_____

_____

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.

_____ _____ _____

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

_____

Relationship to Patient **Legal Authority (Attach Supporting Documents)**