



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):

Table with 4 columns: PFP SW Medical Village., PFP Westlake, PFP Bee Cave, PFP Dripping Springs. Each column lists address, city, state, zip, and fax number.

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)