Premier
MEDICAL GROUP

IDENTIFICATION OF PERSONAL REPRESENTATIVES

Patient: ______________________ **Date of Birth:** ______________ **Daytime Phone #:** ______________

I hereby authorize Premier Medical Group to disclose my protected health information (as described below) to the individual(s) named below. I understand the protected health information released to the individual(s) named below may be further disclosed by the recipient and no longer protected by Federal law. I understand that PMG's patient web portal allows me to make changes to who can access my health records inside the patient portal. However, I also understand that it is the most current edition of this document (Identification of Personal Representatives) that determines to which designated personal representative(s) PMG's staff are permitted to disclose my protected health information.

PARENTS OF CHILDREN 18 YEARS AND YOUNGER

State laws provide access to protected health information by biological parents regardless of marital situation unless a court has imposed alternative parental guardianship, or a parent has legally relinquished parental rights. To assure privacy and protection of a child's protected health care information please list the biological parents below:

Print the Name of Mother	Date of Birth	Home Phone #	Mobile Phone #	Email
Print the Name of Father	Date of Birth	Home Phone #	Mobile Phone #	Email
Print the Name of Legal Guardian	Date of Birth	Home Phone #	Mobile Phone #	Email

If your child has been adopted by you or spouse, please provide a copy of the official adoption decree.

If your child is under joint custody, please provide a copy of the official Custody Order.

If a child is under guardianship, please provide the court documents citing who is the child's legal guardian.

All legal documents provided will be held confidentially and are considered part of the child's medical record, thus will be considered and treated as protected health information.

I authorize Premier Medical Group to disclose the following protected health information:

☐ I hereby authorize Premier Medical Group to disclose ALL of my protected health information (All locations). This information may include clinical information about my care, as well as billing information related to my health insurance coverage and payment activity for services rendered by Premier Medical Group.

☐ I hereby authorize Premier Medical Group to disclose ONLY the protected health information listed below:

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Below are the family members/friends/others who may receive the protected health information described above.

Print the Name of the Personal Representative	Date of Birth	Home Phone #	Mobile Phone #	Email	*Allow Patient Portal Access?* Yes-Full ☐ Yes-Billing Only ☐ No ☐
Print the Name of the Personal Representative	Date of Birth	Home Phone #	Mobile Phone #	Email	*Allow Patient Portal Access?* Yes-Full ☐ Yes-Billing Only ☐ No ☐
Print the Name of the Personal Representative	Date of Birth	Home Phone #	Mobile Phone #	Email	*Allow Patient Portal Access?* Yes-Full ☐ Yes-Billing Only ☐ No ☐
Print the Name of the Personal Representative	Date of Birth	Home Phone #	Mobile Phone #	Email	*Allow Patient Portal Access?* Yes-Full ☐ Yes-Billing Only ☐ No ☐

The purpose of this authorization is (check at least one):

☐ Involvement in the care or payment of care for the patient listed above
☐ At my request
☐ Other: ______________________________

I understand that except to the extent that action already has been taken based on my authorization, I may revoke this authorization at any time by written notification to Premier Medical Group, Attention: Privacy Officer, at the address below.

Premier Medical Group will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my provision of this authorization unless the authorization was for research related treatment and information disclosure, or the treatment is solely for the purpose of disclosing to another individual or business. I understand that I may refuse to sign this authorization and that Premier Medical Group will not retaliate against me if I refuse to do so. I understand I have a right to receive a copy of this authorization.

Signature of Patient or Patient Representative: ______________________ Date: ______________

Printed name of Patient Representative: ______________________

Basis of Patient's Representative to act for individual: ______________________

Please mail this request to:
Privacy Officer
Premier Medical Group, PC
PO Box 3799
Clarksville TN 37043

This form may also be delivered to any Premier Medical Group location as well.