Premier
MEDICAL GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the use and disclosure of my medical information, as indicated below:

Patient's Name: _____ **Date of Birth:** _____

Physician's Name: _____

Office Address: _____

City, State, Zip: _____

Physician's Phone #: _____

I authorize use and disclosure of information for the following reason:

- ☐ Consult/Second Opinion
- ☐ Selecting New Physician
- ☐ Relocating Out of Town
- ☐ Personal
- ☐ Other: _____

I authorize use and disclosure of the following indicated information: (Fees may apply)

I understand there may be a fee for obtaining a copy of my medical information. It is my desire that only the following information indicated below be used and disclosed as a result of this authorization:

The Specific Time Period released information should cover: From _____ To_____

☐ **Complete Chart** - includes any computerized (electronic medical record) and/or paper medical documentation for the patient.

☐ **Specific** medical record content (list item(s) needed): _____

ALSO

I understand my medical record may contain specific health information deemed highly confidential by State and Federal laws that specifically need my additional authorization for disclosure:

- ☐ **Alcohol and drug abuse records held by a substance abuse treatement program**
- ☐ **Records of domestic abuse, sexual assault or child sexual abuse**
- ☐ **Sexually Transmitted Diseases testing , diagnosis and treatment records**
- ☐ **HIV testing and diagnosis and treatment records**
- ☐ **Genetic testing and counseling records**
- ☐ **Psychology records**
- ☐ **Records of psychiatric/mental health treatment by mental health provider**

By initialling this statement, I am authorizing the additional *confidential* information I have checked off above to be released in association with this authorization. PLEASE INITIAL _____FOR USE AND DISCLOSURE.

I authorize the use and disclosure of the information described above to:

Recipient Name: _____

List Any Previous Names _____

Address _____

City, State, Zip: _____

☐ I will Pick Up: Date to be picked up: _____ Daytime Contact #: ( ) _____-_____

☐ Mailed To: ***(If records are coming from Non-Premier practice, note Premier physician receiving records)***

Name: _____

☐ Fax To: Name: _____ Fax: ( ) _____ - _____

(See Other Side)

I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space _____. I understand, that except to the extent that action has been taken based on my authorization, I may revoke this authorization at any time by written notification to Premier Medical Group, ATTN: Privacy Officer , PO Box 3799, Clarksville TN 37043

Patient Rights:

The patient has the right to review the health information used or disclosed under this authorization.

The patient has the right to decline this authorization. Treatment will not be denied 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.

Information that is disclosed under this authorization may be further disclosed by the recipient of the health information and no longer protected by federal law. Premier Medical Group cannot guarantee the further safeguarding of the health information after disclosure.

_____ _____

Date **Patient or Personal Representative Signature**

If signed by personal representative, describe your authority to act for the patient: _____

For Premier Use Only:

Chart #: _____

Release has been: Mailed: _____ Faxed: _____ Date: _____

Records have been: Mailed: _____ Faxed: _____ Date: _____

Picked Up: _____ Date: _____

Employee Signature/Title: _____ Amount Charged: _____

Amount Paid: _____