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.

SPECIFIC TIME PERIOD: The released information should cover FROM _____ TO _____

☐ **COMPLETE CHART:** Includes any computerized (electronic medical record) and/or paper medical documentation for the patient.

☐ **SPECIFIC:** Indicate specific medical record content needed (list items): _____

ADDITIONAL AUTHORIZATION

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 treatment 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
- ☐ Abortion

By initializing this statement, I am authorizing the addition *confidential* information I have checked above to be released in association with this authorization. **PLEASE INITIAL _____ FOR USE AND DISCLOSURE.**

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

Recipient Name	
List Any Previous Names	
Address, City, State, Zip	
Email Address	

☐ I will pick up - Date to be picked up: _____ Daytime contact #: _____

☐ Mail - If records are coming from non-Premier practice, note Premier physician receiving records: _____

☐ Fax – Name: _____ Fax #: _____ ☐ Email

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.

My signature verifies I have read the above statements. My signature also verifies I am aware there may be a charge for the copies of my medical information. I understand I will be notified of and responsible for any copy charges due prior to receipt of my health information.

_____	_____	_____
Date	Patient or Personal Representative Signature	Daytime Phone#

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

For Premier Medical use only

Chart #: _____

Release has been: ☐ Mailed ☐ Faxed Date: _____

Records have been: ☐ Mailed ☐ Faxed Date: _____

Employee Signature/Title: _____

Amount charged: _____

Amount paid: _____