Premier Family Physicians

Authorization for Release of Patient Information

Patient Name _____ **Date of Birth** _____

_____

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

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

Request Records from (Be sure to complete this section to prevent delays in obtaining your records):

Name of Doctor/Organization: _____ **Phone: (____)** _____ **Fax: (____)** _____

Address: _____

Description of information to be release: (please check all that apply)

__ Entire Record __ Immunization Records __ Laboratory Reports __ Radiology/Imaging Reports

__ 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 (please circle one):

Bee Cave	Dripping Springs	Lakeway	SW Medical Village	Westlake
12600 Hill Country Blvd	170 Benney Ln	101 Medical Parkway	5625 Eiger Road	912 S Capital of Texas Hwy
Ste R-103	Ste 200	Ste 210	Ste 200	Ste 100
Austin, TX 78738	Austin, TX 78620	Lakeway, TX 78738	Austin, TX 78735	Austin, TX 78746
Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668

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 recipet 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.

X _____ _____ _____

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