Premier Family Physicians

Authorization for Release of Patient Information

Patient Name ______________________________ **Date of Birth** ____________________

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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):

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 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:

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.

X ______________________________ ____________ ______________________________

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

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Relationship to Patient **Legal Authority (Attach Supporting Documents)**