PREMIER *medical group*

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ____

DATE OF BIRTH: ____________________________________

ADDRESS: ____

____

TELEPHONE: _______________________________________

I hereby authorize ______________________________________ to disclose the following Protected Health Information

(PHI) to ____.

PHYSICIAN PHONE: _______________________FAX: ___________________________

The following information is to be disclosed: (please check off those that apply)

Physician notes ________ Dates ___________
Lab results ___________ Dates ___________
X-Ray reports _________ Dates ___________
Operative reports _____Dates ___________
COMPLETE RECORD ________
Other: ___________

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____________

Signature of patient or patient representative   Date

____   ____________________________