Release of Information

Patient Name: ______________________________________ Patient DOB: _________________

( ) I hereby authorize Premier Family Medical to disclose personal health information e.g., information relating to the diagnosis, treatment, claims payment and health care services provided. This information may be released to:

Name: ___________________________ Relationship: ________________ Phone Number: ___________________

Name: ___________________________ Relationship: ________________ Phone Number: ___________________

Name: ___________________________ Relationship: ________________ Phone Number: ___________________

( ) Information is not to be released to anyone

I authorize the following protected health care information to be disclosed (check one):

- ☐ Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.)
- ☐ Entire medical record for specified date(s) of service: From: _________To: __________
- ☐ ONLY the following specific information: ____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

- Psychological/psychiatric conditions
- Drug and/or alcohol abuse diagnosis and/or treatment
- Genetic testing
- HIV/AIDS diagnosis and/or testing
- Sexually transmitted disease(s) diagnosis and/or testing
- Reproductive health information (pregnancy, contraception, fertility treatment & family planning)

List any restrictions: ____

I understand that unless I provide a written revocation at an earlier date, this authorization will expire in **one year** or as otherwise noted. **Expiration Date**: _________________

Signature: ____ Date: ____________________

Witness: ____ Date: ____________________

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Important Notices

- **Redisclosure of Information:** I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

- **Right to Refuse to Sign this Authorization:** I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

- **Right to Revoke:** I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

- **Right to Inspect:** I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

- **Right to Receive a Copy of Authorization:** I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

- **Photocopy:** A photocopy of this authorization, including a copy that is received by fax or electronically transmitted, shall be considered as effective and valid as the original.