Premiere Physicians Express Urgent Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Other Name: _____

Address: _____ Birthdate: _____

_____ Soc. Sec. No.: _____

_____ Phone (Day): _____

I hereby authorize _____

_____

_____

To release a copy of the following information:

_____

To: _____

_____

_____

☐ For the following purpose(s):

_____

☐ At my request

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuses, and mental health diagnoses and treatment. I do _____ do not _ authorize release of this type of information.

I understand:

1. I may revoke this authorization except to the extent that it has already been acted upon.
2. Treatment may not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
3. Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
4. I may have a signed copy of this authorization.

_____ _____

Patient or Personal Representative's Signature Date