Patient Medical Record Release Authorization

Date: ____________

Patient Name: ________________________________ Date of Birth: ________________

I hereby authorize the release of my personal health information to the following relatives or individuals:

Name: ___________________________________ Relationship: ________________

Name: ___________________________________ Relationship: ________________

Name: ___________________________________ Relationship: ________________

Name: ___________________________________ Relationship: ________________

Name: ___________________________________ Relationship: ________________

Regarding phone messages please check yes or no:

____ ____ Premier may leave messages on my answering machine at home.

Yes No

____ ____ Premier may leave messages with my employer/ at work.

Yes No

The messages we leave will include only your physician's name, the caller's name, appointment times and the phone number where you may reach us. We will not leave test results on answering machines or voice mail.

For the purpose of your treatment and our payment and operations we will disclose your protected health information to physicians, other medical professionals, hospitals and insurance companies. Otherwise it is our policy to release such information only to the patient unless otherwise specified authorized to do by you in writing. **This authorization will not expire unless revoked by you by giving us written notice of such revocation**. Information disclosed under this authorization may be disclosed again by the person or organization to which it is given and is no longer protected by federal privacy regulations.

I hereby authorize Premier Surgical Associates to release my protected health information to the individuals listed above.

Patient Signature____________________ Guardian Signature____________________

Date:______________________________ Date:______________________________