PREMIER

FAMILY MEDICINE - URGENT CARE - WELLNESS - DENTAL

Authorization to Request Medical Record Information

1037 State Road 7, Wellington FL 33414 – Phone: 561-798-3030 Fax: 561-798-8242

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Requesting Records from:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Requesting the Release of the following Medical Records to Premier Family Health:

I hereby authorize Premier Family Health to receive the following Medical Records Information

☐ Private Insurance claim for the date/dates of service: _____

☐ All my Medical Records for all dates of service.

☐ Specific Diagnostic Imaging / Testing Done: _____

☐ Other: _____

Authorization to Release Protected Information to Premier Family Health:

Required – Please completed the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records. **Initial each line below to confirm your choices.**

I ☐ DO ☐ DO NOT want **Psychiatric Treatment** Notes released to Premier. _____

I ☐ DO ☐ DO NOT want information about **Mental Health** released to Premier. _____

I ☐ DO ☐ DO NOT want information about **HIV Tests & Related Information** released to Premier. _____

I ☐ DO ☐ DO NOT want information about **Alcohol and/or Substance Abuse** released to Premier. _____

I ☐ DO ☐ DO NOT want information about _____ released to Premier. _____

Other Sensitive Information?

_____ _____

Patient Signature Date

_____ _____

Parent/Legally Recognized Representative Signature Date

*By my signature, I attest that I am the legally recognized representative of the above mentioned patient.

The information release pursuant to this authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to