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****NO CD MEDICAL RECORDS****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **DOB**: _____/_____/_____

Phone: _____ **Email:** _____

I authorize PremierMED Family & Sports Medicine to obtain from the following:

☐ **Progress Notes** ☐ **Radiology Reports** ☐ **Pathology Reports**

Dates: _____**to**_____ ☐ **All Diagnostic Results** ☐ **All Medical Records**

Please release my health information from the following providers/facilities:

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

The information may be used for the following purposes:

☐ **Continued Treatment** ☐ **Insurance** ☐ **Personal use**

☐ **Disability** ☐ **Legal** ☐ **Other:** _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form maybe revoked in writing and otherwise expires five years from the date listed below.

Patient Signature: _____ **Date:** _____/_____/_____

**Note: If these records contain any information from previous providers, or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

*****This form expires one year from the signed date*****