Authorization for Release of Patient Medical/Dental Information

P.O. Box 232 ● Dade City, FL 33526 ● Phone (352) 518-2000 ● Fax (352) 567-0218

Release medical record of:

Patient Name	Date of Birth	Date(s) of service

I authorize the physicians and staff of Premier Community HealthCare Group, Inc., to release the above named individual's health information as described below, which would include medical or dental records.

I authorize Premier to make disclosure to the individual or organization identified below: mark as applicable

□ **RELEASE TO** □ **RECEIVE FROM** □ **EXCHANGE WITH**

Name of person or agency: ____

Address: ________________________________ **Phone:** ______________ **Fax:** ______________

Please CHECK all areas that apply to be used or disclosed, mark as appropriate.

- □ Diagnosis
- □ Diagnostic Testing Results
- □ Entire Medical Record or for Specific Dates______________
- □ Financial, Billing and/or Claim Information
- □ **HIV Test Results– *Initials required*** ___________
- □ Hospital Records for Specific Dates:____________________
- □ Immunization Records
- □ Laboratory Results
- □ Medication List & History Laboratory Results
- □ Most recent History & Physical
- □ Progress Notes
- □ Vitals

BEHAVIORAL MENTAL HEALTH RECORDS

- □ Psychiatric Evaluation
- □ Psychiatric Medication Management Notes
- □ Psychosocial Assessment
- □ Other ________________________________

PURPOSE OF DISCLOSURE

- □ Attorney related
- □ Communication with School
- □ Continuity of Care
- □ Court Related Matters
- □ Disability
- □ Information for Insurance Company
- □ Other – list reason ____________________________
- □ Personal Use

I understand that the information in my health record may include information relating to sexually transmitted disease and other reportable diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral, psychiatric or mental health services, and treatment for alcohol and drug abuse.

AUTHORIZED BY: □ Patient □ Authorized Representative □ Parent □ Legal Guardian □ Surviving Spouse □ Administrator/Executor of Estate □ Other (specify) ______________________

Signature of Patient:____________________________ **Authorization Date:**__________ ____________________

*******If legal guardian, administrator or executor of estate; legal proof of this status must accompany this authorization**** ***

Witness:____________________________________ **Date:** ______________________________

PCHG Care Team Member

The patient or authorized representative may revoke this authorization at any time (after it is signed) by submitting a written request to the facility. This authorization will expire automatically one (1) year after the date signed.

NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS: PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by State Law and HIPAA regulations. State law prohibits you from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by state law. General medical authorization to release psychiatric and or psychological, HIV, and drug and alcohol information is invalid according to the Florida Statute 394.459, 381.004, 396.11, and or 90.503 and Federal Regulation 42 CFR part 2. Your records will not be released without this specific waiver, except under the following circumstances: a valid emergency, upon receipt of a Court Order, or upon receipt of a request which may be governed by other Florida Statutes, such as Workers Compensation, etc. When exchanging information, in cases where the consumer is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal as well as written communication.

FOR INTERNAL USE ONLY: A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED

Release date:______________ ***by:***______________________ □ *PAPER* □ *ELECTRONIC* □ *MAILED* □ *IN PERSON* ***(ID Required)***