

# PREMIER FAMILY MEDICINE

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS – FAMILY RELEASE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ SS#: \_\_\_\_\_

\_\_\_\_\_  
Phone#: \_\_\_\_\_

By signing this authorization, I am requesting that a copy of my protected health information (PHI) be disclosed:

**TO:**

\_\_\_\_\_  
(Practice, Physician, Organization)

\_\_\_\_\_  
(Mailing Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Fax Number)

**FROM: (Required)**

**Premier Family Medicine**

\_\_\_\_\_  
(Practice, Physician, Organization)

**304 Ashby Park Lane**

\_\_\_\_\_  
(Mailing Address)

**Greenville, SC 29607**

\_\_\_\_\_  
(City, State, Zip Code)

**864-286-9050**

\_\_\_\_\_  
(Phone Number)

**864-286-6885**

\_\_\_\_\_  
(Fax Number)

I have Initialed Each Item approved for disclosure of my personal medical information below:

\_\_\_\_\_ Medical Information Only

\_\_\_\_\_ Billing Information Only

\_\_\_\_\_ Any and All Information with No Restrictions

\_\_\_\_\_ Other: \_\_\_\_\_

All identifiable health information about me including progress notes, history and physicals, laboratory reports, consultations, radiological reports, and other pertinent information should be released to the above entity/person. I understand that the records may contain information of a personal and confidential nature and may include reference to infectious disease, psychiatric care, sexual assault, alcohol abuse or drug abuse.

**My signature below indicates that I have read and understand this Authorization of Release of Medical Records. This authorization may be revoked at any time by notifying Premier Family Medicine in writing.**

\_\_\_\_\_  
Patient Signature (or Legal Representative)

\_\_\_\_\_  
Date

**NOTE: The release of medical records from our office as hardcopy will follow the SC Code of Laws Title 44 Chapter 115 and will incur the state allowed fees. Payment in advance is required.**

Premier Family Medicine use only:

Date Records Sent/Faxed: \_\_\_\_\_