PREMIER FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:______________________________ Date of Birth:________________

Patient Address: ____________________________ SS#:________________________

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____________________________ Phone#:_____________________

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

TO: (Required)	**FROM:**
____________________________	Premier Family Medicine
(Practice, Physician, Organization)	(Practice, Physician, Organization)
____________________________	304 Ashby Park Lane
(Mailing Address)	(Mailing Address)
____________________________	Greenville, SC 29607
(City, State, Zip Code)	(City, State, Zip Code)
____________________________	864-286-9050
(Phone Number)	(Phone Number)
____________________________	864-286-6885
(Fax Number)	(Fax Number)

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. Any limitations to this statement are noted as follows:____

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This authorization may be revoked at any time by notifying both of the above parties in writing. Without revocation, this authorization will automatically expire within 45 days of the receipt of this signed authorization.

My signature below indicates that I have read and understand this Authorization of Release of Medical Records.

______________________________________ ______________

Patient Signature (or Legal Representative) Date

NOTE: **The fee for release of medical records from this office is in accordance with the S.C. Code of Laws Title 44 Chapter 115: Retrieval Fee $15 plus $.65 per page for pages 1-30 and $.50 per page for all other pages plus applicable postage. Payment in advance is required.**

Premier Family Medicine use only:	Date Records Sent/Faxed: __________________