PREMIER FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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 for the purpose of Continuity of Care:

TO:	**FROM: (Required)**
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:_____

_____

_____

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 release of medical records from any office may have a fee. Please check with the entity you are requesting records from if this is a concern.**

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