REQUEST FOR RELEASE OF INFORMATION

Patient's Name: _____
Last First MI Maiden (Please include all names by which the patient has been known)

Date of Birth:___/___/___ S.S.#_____ Medical Record # _____

I HEREBY AUTHORIZE PREMIER MEDICAL MANAGEMENT, INC.

To Release to: _____ **OR** To Obtain From: _____

At this Address: _____

PURPOSE FOR RELEASE:

_____ Legal _____ Insurance _____ Evaluation and Treatment Other_____

DATE OF SERVICES TO BE RELEASED: FROM_____ TO_____

AND/OR

TYPE OR CATEGORY OF MEDICAL INFORMATION TO BE RELEASED (Example; Audiology, sinus surgery, eye exam, all records)

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1. I understand that the above record request may contain information concerning sexually transmitted disease and / or treatment, drug and / or alcohol tests and treatment, psychiatric treatment, and HIV / AIDS tests or treatment, and **I AM SPECIFICALLY PERMITTING** Premier Medical Group to include this information in the records release.

_____ _____
Signature of Patient/ Legal Representative Date

2. I understand that the above record request may contain information concerning sexually transmitted disease and / or treatment, drug and / or alcohol tests and treatment, psychiatric treatment and HIV / AIDS tests or treatment **I AM SPECIFICALLY *NOT* PERMITTING** Premier Medical Group to include this information in the records release.

_____ _____
Signature of Patient/ Legal Representative Date

3. I understand this authorization may be revoked in writing at any time by submitting a letter to the medical records supervisor, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed below.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

I acknowledge that I have read and fully understand this authorization as it applies to me. By my signature, I authorize execution of the terms of this document.

_____ _____
Signature of Patient/ Legal Representative Date

As a legal representative, I have authority to act for the individual because I am: _____

_____ _____
Witness Date

East
2880 Dauphin St.
Mobile, AL 36606
Ph 251-470-8934
Fax 251-470-8944

West
3701 Dauphin St.
Mobile, AL 36608
Ph 251-341-3315
Fax 251-345-8979

ProvidenceENT
610 Providence Park
Building 2 Suite 203
Mobile, AL 36695
Ph 251-633-2667
Fax 251-633-2179

ProvidenceEYE
610 Providence Park
Building 2 Suite 202
Mobile, AL 36695
Ph 251-635-0919
Fax 251-635-0924

Jackson
1206 College Ave.
Jackson, AL 36545
Ph 251-246-3231
Fax 251-246-3034

Fairhope
5 Medical Park Dr.
Fairhope, AL 36532
Ph 251-928-2302
Fax 251-928-2308