AUTHORIZATION TO OBTAIN PATIENT INFORMATION

Patient's name: ____

Date of Birth: ____

Please give complete address & phone number for Physician or Facility that we are requesting information from

I request and authorize:

Name: ____

Address: ____

City, State: ______________________________ Zip Code: ______________

Phone: ______________________ FAX: ______________________

To release my health information to: **Premier HealthCare Associates, Inc.**
7702 E. Parham Road Suite 101
Richmond, VA 23294
804 288-7901 FAX 804 273-9167

The information released will be used for the following purpose: ______________________

This authorization applies to the following information:

___Most recent office note and labs ___ last 2 years of office notes and labs ___ Entire Record

___ Other Specifically: ____

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I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

PLEASE NOTIFY THE PATIENT IF THERE ARE ANY FEES ASSOCIATED WITH THIS REQUEST PRIOR TO RELEASING THE INFORMATION.

The patient can be reached at:______________________*(Please list a number where you can be reached)*

This release is effective for 90 days from the date signed, unless otherwise specified.

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Signature of patient Date

____

Patient Representative Relationship Date