AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient's name: ____

Date of Birth: ____

I request and authorize **Premier HealthCare Associates, Inc**. to release my health care information to the following:

Please give the Name and address of individual or entity to receive the information

Name: ____

Address: ____

City, State: ______________________ Zip Code: ____________

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: ____

____

I understand I have the right to access my health record in accordance with the law and the policies of Premier HealthCare Associates, Inc. I understand that Premier HealthCare Associates may charge me for copies of my health records. **I understand the Premier HealthCare Associates will notify me of any charges prior to releasing my health records.**

I understand that Premier HealthCare Associates, Inc. has the right to deny me access to my records in certain circumstances in accordance with the law. If Premier HealthCare Associates denies me access to my health record, I understand that I will be provided with the reasons for denial in writing and describe weather I have the right to a review of the denial performed by a licensed health care professional.

Please note that information disclosed in pursuant to this request is no longer under the control of Premier HealthCare Associates, Inc. and may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization in writing at any time.

____

Signature of patient Date

____

Patient Representative Relationship Date