Premier Family Medicine, LLC

Request for Release of Protected Health Information

You are allowed access to your protected health information, with certain exceptions. Elements of your protected health information that may be restricted from access are listed in our Notice of Privacy Practices. If access is granted, you will be allowed to inspect these records in person and/or request a copy of the records as a readable printed copy, or in another format. Alternatively, you can ask for a summary of your protected health information. Please understand, there are staffing and materials cost to produce a copy of your medical records and under Indiana law, your provider may charge you an appropriate fee to cover those costs. Our office uses a HIPAA Compliant copy service to gather, scan and deliver a copy of your medical records. You will be billed by them before your records are sent. You should expect the same from your other healthcare providers.

Patient Name	Social Security Number	Date of Birth

Patient's Home Address	City	State	Zip Code

I hereby authorize a copy of patient's/my medical records to be released TO:

Name **Premier Family Medicine, LLC**	Phone **317-789-9600**	Fax **317-789-0600**

Address **747 E. County Line Road, Suite B**	City **Greenwood**	State **IN**	Zip Code **46143**

I hereby authorize a copy of patient's/my medical records to be released FROM:

Name of Doctor or Doctor's Office	Phone	Fax

Address	City	State	Zip Code

Information to be released:

- ☐ All Records (with exception of those requiring special consent)
- ☐ Immunization Records
- ☐ Lab Reports
- ☐ Summary of patient treatment/diagnosis from _____ to _____ needed for continuity of care
- ☐ Other: (explain) _____

Disclosures requiring SPECIAL CONSENT: (check all that apply)

☐ HIV/AIDS ☐ Communicable Disease Records ☐ Mental Health Records ☐ Drug/Alcohol Treatment Records

Reason/Need for disclosure:

☐ Treatment ☐ Transfer to New Family Doctor ☐ Other:_____

-I understand that I have the right to inspect the information to be released and I may withdraw this authorization. I understand that this authorization will expire, without my express revocation, 60 days from the date written below. I also understand that there may be fees associated with copying/mailing this information.

-To stop this Authorization, I must write a letter to the appropriate party. Stopping the Authorization will not apply to information that was already sent in response to the Authorization.

-Information used or disclosed may be disclosed again by the person or organization that received it and may no longer be protected by Federal Privacy Rules.

-Treatment cannot be denied for refusing to sign this authorization form.

Patient/Consenting Party (if patient is a minor) Relationship to Patient _____

Print Name _____ Signature _____ Date _____

A photocopy or facsimile of this authorization shall be valid as the original

Note: This information is disclosed from records, the confidentially of which are, protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.