PREMIER Community HealthCare

Authorization for Release of Patient Medical/Dental Information

P.O. Box 232 ● Dade City, FL 33526 ● Phone (352) 518-2000 ● Fax (352) 567-0218

Release medical record of:

Patient Name	Date of Birth	Date(s) of service

I authorize the physicians and staff of Premier Community HealthCare Group, Inc., to release the above named individual's health information as described below, which would include medical or dental records.

I authorize Premier to make disclosure to the individual or organization identified below: mark as applicable

□ **RELEASE TO** □ **RECEIVE FROM** □ **EXCHANGE WITH**

Name of person or agency: _____

Address: _____ **Phone:** _____ **Fax:** _____

Please CHECK all areas that apply to be used or disclosed, mark as appropriate.

□ Diagnosis
□ Diagnostic Testing Results
□ Entire Medical Record or for Specific Dates_____
□ Financial, Billing and/or Claim Information
□ **HIV Test Results– *Initials required*** _____
□ Hospital Records for Specific Dates:_____
□ Immunization Records
□ Laboratory Results
□ Medication List & History Laboratory Results
□ Most recent History & Physical
□ Progress Notes
□ Vitals

BEHAVIORAL MENTAL HEALTH RECORDS

□ Psychiatric Evaluation
□ Psychiatric Medication Management Notes
□ Psychosocial Assessment
□ Other _____

PURPOSE OF DISCLOSURE

□ Attorney related
□ Communication with School
□ Continuity of Care
□ Court Related Matters
□ Disability
□ Information for Insurance Company
□ Other – list reason _____
□ Personal Use

I understand that the information in my health record may include information relating to sexually transmitted disease and other reportable diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral, psychiatric or mental health services, and treatment for alcohol and drug abuse.

AUTHORIZED BY: □ Patient □ Authorized Representative □ Parent □ Legal Guardian
□ Surviving Spouse □ Administrator/Executor of Estate □ Other (specify) _____

Signature of Patient:_____ **Authorization Date:**_____
*******If legal guardian, administrator or executor of estate; legal proof of this status must accompany this authorization*******

Witness:_____ **Date:** _____
PCHG Care Team Member

The patient or authorized representative may revoke this authorization at any time (after it is signed) by submitting a written request to the facility. This authorization will expire automatically one (1) year after the date signed.

NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS: PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by State Law and HIPAA regulations. State law prohibits you from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by state law. General medical authorization to release psychiatric and or psychological, HIV, and drug and alcohol information is invalid according to the Florida Statute 394.459, 381.004, 396.11, and or 90.503 and Federal Regulation 42 CFR part 2. Your records will not be released without this specific waiver, except under the following circumstances: a valid emergency, upon receipt of a Court Order, or upon receipt of a request which may be governed by other Florida Statutes, such as Workers Compensation, etc. When exchanging information, in cases where the consumer is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal as well as written communication.

FOR INTERNAL USE ONLY: A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED

Release date: _____ ***by:***_____ □ *PAPER* □ *ELECTRONIC* □ *MAILED* □ *IN PERSON* ***(ID Required)***

PREMIER
Community HealthCare

Autorización Para Duplicar y Enviar Información Médica/Dental del Paciente

P.O. Box 232 ● Dade City, FL 33526 ● Phone (352) 518-2000 ● Fax (352) 567-0218

Enviar Registro de Salud Médico o Dental de:

Nombre del Paciente	Fecha de Nacimiento	Fecha(s) de Servicio

Yo autorizo a los médicos o empleados de Premier Community HealthCare Group, Inc., duplicar o enviar el expediente medico y/o información de la salud del individuo indicado, que incluiría registros médicos o dentales.

Yo autorizo a Premier que revele la información del individuo a la organización indicada:

Marque lo que aplique: □ **Duplicar/Enviar** □ **Recibir/Aceptar** □ **Intercambiar**

Nombre de la persona o agencia: _____

Dirección _____**Telefono:** _____**Fax:**_____

Por favor, verifique todas las áreas y MARQUE lo que aplique:

□ Diagnósticos
□ Expediente del Hospital–especifique fechas _____
□ Expediente médico completo, específica fechas _____
□ Financiera, facturación y/o reclamaciones de facturación
□ Historia y Físico
□ Lista de medicamentos y resultados de laboratorio
□ Los resultados de diagnósticos
□ Notas de Progreso
□ **Pruebas del VIH/SIDA – *Requiere Iniciales*** _____
□ Registros de Inmunización
□ Resultados de laboratorio
□ Signos Vitales

REGISTROS DE SALUD MENTAL

□ Evaluación Psicosocial
□ Evaluación psiquiátrica
□ Medicamento psiquiátrico y notas
□ Otro Uso _____

PARA EL PROPÓSITO DE

□ Asuntos relacionados con la corte
□ Comunicación con la Escuela
□ Continuidad de atención medica
□ Incapacidad
□ Información para Compañía de Seguros
□ Otra razón o motivo
□ Relacionado con abogado
□ Uso Personal

Entiendo que la información de mi Registro de Salud puede incluir información relativa a enfermedades de transmisión sexual y otras enfermedades de notificación obligatoria, el síndrome de inmunodeficiencia adquirida (SIDA) o el virus de la inmunodeficiencia humana (VIH). También puede incluir información psiquiátrico o los servicios de salud mental y tratamiento para abuso de alcohol y drogas.

Autorizado(s) por: □ Paciente □ Representante Autorizado □ Padres □ Guardian Legal
□ Esposo o Esposa □ Administrador/Ejecutor de Bienes Sobreviviente □ Otro (Especifique) _____

Firma de Paciente: _____**Fecha de Autorizacion:**_____
**********Si Guardian Legal, administrador, o albacea de herencia, prueba legal debe acompañar esta autorización**********

Witness/Testigo:_____ **Fecha:** _____
PCHG Care Team Member

El paciente o representante autorizado puede revocar esta autorización en cualquier momento (después de que haya sido firmado) mediante el envío de una solicitud por escrito a Premier. Esta autorización caducará automáticamente un (1) año después de la fecha de la firma.

NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS: PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by State Law and HIPAA regulations. State law prohibits you from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by state law. General medical authorization to release psychiatric and or psychological, HIV, and drug and alcohol information is invalid according to the Florida Statute 394.459, 381.004, 396.11, and or 90.503 and Federal Regulation 42 CFR part 2. Your records will not be released without this specific waiver, except under the following circumstances: a valid emergency, upon receipt of a Court Order, or upon receipt of a request which may be governed by other Florida Statutes, such as Workers Compensation, etc. When exchanging information, in cases where the consumer is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal as well as written communication.

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