PREMIER PHYSICIANS

# Authorization Form For Release of Protected Health Information

**We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.**

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ Medical ☐ Financial ☐ Other: _____

Release my protected health information to the following person(s)/entity:

Name: _____Relation _____ Phone: _____

Name: _____ Relation _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

**Privacy Officer Premier Physicians 4214 Andrews Hwy, Ste.240 Midland, TX 79703**

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.**

_____ _____ _____

Signature of Patient Date of Birth Date

_____ _____

Signature of Personal Representative Relationship to patient (or other authority)