SUBMIT

Consent for the Release of Medical Information To Specified Individuals

PREMIER HEALTH CENTER, LLC

Is committed to the protection of your personal health information. However, we recognize the individuals at times require others to assist with their health care needs. In accordance with HIPAA regulations, we ask that you take a moment to record the names of individuals with whom we are allowed to discuss your medical appointments, condition, treatment options, insurance payment arrangements and other information necessary for us to carry out our responsibilities in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may communicate, in whole or in part, about your personal health information. If you do not list any names, we will not discuss your medical information with anyone other than yourself.

PATIENT'S SIGNATURE _____ DATE _____

PARENT'S SIGNATURE _____ DATE _____

CONTACT/RELATIONSHIP TO PATIENT: PHONE #

1) _____ _____

2) _____ _____

Please indicate below the methods in which messages may be left for you, the patient:

(Y / N) Messages may be left on my home answering machine.

(Y / N) Messages may be left on my cell phone Voice Mail: Cell # _____