PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

PATIENT RECORDS REQUEST

Patient Name: ____ **Date of Birth:** ___________________

_____ **I authorize the release of my ENTIRE medical record to**: **PREMIER PSYCHIATRY**

Email: premierpsychiatry@thaparmd.com

_____ **I authorize ONLY the release of** ___________________ **to: Fax: (708) 799-1305**

This release applies to (Provider/Facility Name):`

Name: ____

Address: ____

City: _________________________ State: ___________________ Zip Code: ______________

Phone: (   ) ________ - ________________   Fax: (   ) _________ - _________________

● I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed, as described above, may no longer be protected by these laws and may be re-disclosed.

● I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment, or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.

● I understand that I have the right to inspect or copy any of the information disclosed by this authorization.

● I understand that I have the right to revoke this authorization at any me, in writing, except to the extent that Premier Psychiatry has already acted in reliance upon this authorization as shown by my signature below and as explained.

● I understand that Premier Psychiatry and its employees are released from any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.

● I understand that I may request a copy of this signed authorization form.

Patient Signature: ____ **Date Signed:** ____________________

Parent/Guardian Signature: _________________________________ **Date Signed:** ____________________
(Patients under 18 years of age)