Primary Health SM
Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name_____ ("Patient") DOB_____

1. **Entity who is authorized to release Patient's information:**

   Name _____ Fax _____Phone _____

2. **Entity(ies) to whom the Patient's information may be disclosed:**

   Name _____

   Address_____

   Phone _____ Fax _____

3. **The specific information that should be disclosed:**

   _____ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS _____ LAST 12 MONTHS OFFICE NOTES/LABS/X-RAYS

   OTHER (BE SPECIFIC):

   _____

4. **The purpose for the disclosure is:** _____

5. **This authorization will expire on the following date or event:** _____

   If no expiration date or event is listed, the authorization will expire two years after the date of the authorization.

   WE PROVIDE THE PAST TWO YEARS OF ELECTRONIC RECORDS FREE OF CHARGE IF GOING TO THE PATIENT OR ANOTHER PHYSICIAN. The patient will be charged copying fees for any additional records as follows: up to 50 pages $15, 51-100 pages $25, and anything over 100 pages $50. There will be an additional $10 charge per chart that must be retrieved from our storage facility. PHMG requires pre-payment for records.

   Signed:

   _____ Date_____
   Patient

   _____
   Personal Representative

   _____
   Authority of Personal Representative (e.g., parent, guardian, etc.)