Premier
OB/GYN, LLC
5323 4th Avenue Circle East
Bradenton, Florida 34208

RELEASE OF MEDICAL INFORMATION

This authorization grants permission to the party named below to any and all medical records, including but not limited to: appointment information and scheduling; radiology, pathology, laboratory, or any other test findings; telephone communication and answering machine messages as well as any other common means of communication; medication information, including picking up non-narcotic medications; diagnosis and treatment plans; and financial health information.

I hereby authorize Premier OB/GYN, LLC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

PATIENT NAME: _____

DOB: _____ ID #: _____

NAMED PARTY: _____

RELATIONSHIP TO PATIENT: _____

☐ I DECLINE TO DISCLOSE MY INFORMATION

I understand that this authorization will expire 1 year from the date signed unless otherwise revoked. I understand that I may revoke this authorization at any time by notifying Premier OB/GYN, LLC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Premier OB/GYN, LLC prior to their receipt of the revocation.

_____ _____
Patient Signature Witness Signature

_____ _____
Date Date

****PLEASE NOTE: This release must be witnessed by a member of the Premier OB/GYN, LLC staff.**