

ID #: _____

Premier

OB/GYN, LLC

5323 4th Avenue Circle East
Bradenton, Florida 34208

HIPAA RELEASE OF MEDICAL INFORMATION

I hereby authorize Premier OB/GYN, LLC to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that my health care provider cannot guarantee that the recipient will not re-disclose 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: _____

NAMED PARTY: _____ RELATIONSHIP: _____

Do not list other Healthcare providers. This is only for friends, family, or other personal relationships.

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AUTHORIZATION: (Choose all that apply)

- Billing information
- Limited to: (Choose all that apply)
 - Birth Control
 - STD testing
 - Pregnancy
 - All of my medical related information (billing included)
 - Other _____
- 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