

**Premier Medical Clinic**  
**315 E. Ash Street**  
**Perry, Florida 32347**  
**Office: (850) 584-3278**  
**Fax: (850) 584-8171**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_  
to release:

- |                     |                         |                     |
|---------------------|-------------------------|---------------------|
| { Discharge Summary | { ECG/EEG/Cardiac Cath. | { Operative Notes   |
| { Pathology Reports | { Laboratory Reports    | { Radiology Reports |
| { Emergency Reports | { History & Physical    | { Progress Notes    |
| { All Records       | { Other _____           |                     |

Dates of Service: \_\_\_\_\_

\_\_\_\_\_ I do \_\_\_\_\_ I do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV ( Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION TO BE RELEASED TO:

**Premier Medical Clinic**  
**315 East Ash Street**  
**Perry, Florida 32347**

**Attention: Dr. Abdo / Dr. Afsh / R. Hearne, ARNP / Dr. Mahinrad / Dr. Sofi / Dr. Yu**

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign this authorization.

\_\_\_\_\_  
Signature of Individual or Guardian or  
Personal Representative of Patient's Estate

\_\_\_\_\_  
Date

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