Premiere Health and Wellness

1710 ½ Alice Street
Waycross, Ga 31501
912-809-2341
888-815-0948 Fax

RECORDS RELEASE

Patient Name _____ **Date of Birth:** _____

Address _____

City/State/Zip_____ **Phone Number:** _____

I authorize Premiere Health and Wellness to obtain my medical information. I also give Premiere Health and Wellness permission to speak with any physician at any time in reference to me or my medical condition.

Release Records From:

Clinic/Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____

Medical Records Requested

- ☐ **All Records**
- ☐ Specialty Provider Referral Notes
- ☐ Labs Only
- ☐ XRay Only
- ☐ Diagnostic Test Results
- ☐ Biote Treatment Only
- ☐ Other: _____

Release Records To:

Clinic/Provider Name: Premiere Health and Wellness Dawn Driggers, NP

Phone: 912-809-2341 Fax: 888-815-0948

Address: 1710 ½ Alice St. Waycross, Ga 31501

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Premiere Health and Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the term and conditions of this authorization.

_____ _____

Signature of Patient/Authorized Rep Date