PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
o: 435.216.9290 | 435.865.9119 | f: 435.865.9115
1490 E Foremaster Dr., Suite 340 – St. George, Utah 84790

Authorization to Use and Disclose Protected Health Information

Patient Name:			
Current Address	City	State	Zip
Phone Number		Date of Birth	

This authorization is to release the protected health information to:

Facility Name/Provider: **Premier Psychological Counseling and Consulting , PC & Premier TMS**		Phone Number: (435) 216-9290	
Address: 1490 E Foremaster Dr., Suite 340	City: St. George	State: UT	Zip: 84790

Deliver by:

Fax => Fax Number: 435-865-9115

This authorization is to release the protected health information from:

Facility Name/ Provider	Phone Number

The purpose of this disclosure is: Coordination of Care

Dates of service requested: ALL

Release the following information:

Patient Health Information:

☐ Continuity of Care Information-(ALL documents, notes, etc. in patient file)

☐ Mental Health Therapy Records
☐ Progress Notes
☐ TMS Records
☐ Behavioral Health Admitting Evaluation
☐ Behavioral Health Discharge Summary
☐ Other Protected Health Information as specified:

Financial:

☐ Insurance Provider & Prescriber ID

This Authorization will remain in effect from the date of this authorization for 180 days or until the following event occurs: _____

I understand that:

- Once *"this facility"* discloses my health information by my request, it 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 may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to Premier Psychological Counseling and Consulting, PC. If I revoke this Authorization, Premier PCC, PC may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of *"this facility"* treatment of me, enrollment in the health plan, or eligibility for benefits.

Signature of Patient or Personal Representative: _____ Date _____

If Signed by Personal Representative, please explain relationship to patient:

_____

Sign this form and submit a copy to your provider and one to Premier PCC.