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 or name of individual | Phone Number

Address | City | State | Zip

Deliver by:

☐ In Person ☐ Mail ☐ By Phone ☐ Fax Fax Number:

This authorization is to release the protected health information from:

Facility Name/Provider: **Premier Psychological Counseling and Consulting , PC & Premier TMS** | Phone Number (435) 216-9290

The purpose of this disclosure is: Coordination of Care

Dates of service requested: ALL

Release the following information: ☐ ALL documents, notes, etc. in patient's files

Patient Health Information:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Operative report(s)
- ☐ Progress notes
- ☐ Pathology report(s)
- ☐ Radiology report(s)
- ☐ Lab report(s)
- ☐ Cardiology report(s)
- ☐ Treatment Plan(s)
- ☐ Contact Information for non-emergent transportation services
- ☐ Behavioral Health Admitting Evaluation
- ☐ Behavioral Health Discharge Summary
- ☐ Mental Health Therapy Records
- ☐ Substance Use Disorder Treatment Record(s)
- ☐ Emergency record(s)
- ☐ Other Protected Health Information as specified _____

Financial:

- ☐ Itemized Billing Statement
- ☐ Financial Information

This Authorization will remain in effect:

☐ From the date of this Authorization or until the following event occurs:_____

Unless otherwise noted above this, authorization will remain in effect 180 days from the date signed.

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:

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