



IDENTIFICATION OF PERSONAL REPRESENTATIVES

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

I hereby grant the individual(s) named below access to my protected health information. This individual may receive and act upon information received from Premier medical Group. This information may include clinical information about my care, as well as billing information related to my health insurance coverage and payment activity for services rendered by Premier Medical Group.

I understand I may revoke this authorization at any time.

I understand the protected health information released to my personal representative(s) may be further disclosed by the recipient. Premier Medical Group cannot guarantee the further safeguarding of the health information after disclosure.

PARENTS OF CHILDREN 18 YEARS AND YOUNGER
State laws provide access to protected health information by biological parents regardless of marital situation unless a court has imposed alternative parental guardianship, or a parent has legally relinquished parental rights. To assure privacy and protection of a child's protected health care information please list the biological parents below:

Print the Name of Mother Date of Birth Social Security Number Daytime Phone #
Print the Name of Father Date of Birth Social Security Number Daytime Phone #
Print the Name of Legal Guardian Date of Birth Social Security Number Daytime Phone #

If your child has been adopted by you or spouse, please provide a copy of the official adoption decree.

If your child is under joint custody, please provide a copy of the official Custody Order.

If a child is under guardianship, please provide the court documents citing who is the child's legal guardian.

All legal documents provided will be held confidentially and are considered part of the child's medical record, thus will be considered and treated as protected health information.

If nothing has been marked below, then my personal representative(s) will have access to my protected health information at all Premier Medical Group locations.

- I hereby grant my personal representative(s) to have access to my protected health information throughout Premier Medical Group (All Locations).
I hereby grant my personal representative(s) to ONLY have access to my protected health information at this location (List):

Patient/Parent/Legal Guardian's Signature Date Signed

Below are My Personal Representative(s):

Print the Name of the Personal Representative Date of Birth Social Security Number Daytime Phone #
Print the Name of the Personal Representative Date of Birth Social Security Number Daytime Phone #
Print the Name of the Personal Representative Date of Birth Social Security Number Daytime Phone #
Print the Name of the Personal Representative Date of Birth Social Security Number Daytime Phone #

Please mail this request to:
Privacy Officer
Premier Medical Group, PC
PO Box 3799
Clarksville TN 37043

This form may also be delivered to any Premier Medical Group location as well.