PrimeNet MEDICAL GROUP INC.

7189 Pembroke Road
Pembroke Pines, FL 33023
954-983-1220
954-983-0687
www.primenetmedical.com
faxpp@primenetmedical.com

Authorization for Release of Medical Records

Patient Name: _____

DOB: _____ SS#: _____

I hereby authorize: _____

Phone number: (_____) _____-_____ Fax number:(_____) _____-_____

ATTENTION: MEDICAL RECORDS DEPARTMENT

Release of Medical Information To:
PrimeNet Medical Group Inc.
7189 Pembroke Road, Pembroke Pines, Florida 33023
Phone: (954)983-1220 Fax: (954)983-0687
Email: faxpp@primenetmedical.com

Purpose of Disclosure: □ Continuation of Care □ Other: _____

Please include all information regarding assessment, diagnosis, treatment, and laboratory results for the above listed patient. Date of service release FROM: _____ / _____ TO: _____ / _____

I understand that I may 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 the practice manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to PrimeNet Medical Group Inc.
I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, sexually transmitted diseases, HIV test results or diagnosis, and alcohol or drug abuse. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization.
I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.
I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar and fully understand the terms and conditions of this authorization.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**

Authorizations and Consents

Access to Prescription History

Our medical practice has adopted an electronical medical records system which will further enhance the quality of our services. This system allows us to collect and review your medical history. A medication history is a list of prescription medicines that we or other doctors have prescribed to you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect your medication history without limitation or exclusion as is required and/or reasonably necessary for your care and treatment. Please understand that your medication history might not include over the counter medicines, supplements, or herbal remedies.

Authorization to Share Health Information

I authorize PrimeNet Medical Group Inc to release any information regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates. This includes leaving messages on the designated contact phone numbers. PrimeNet Medical Group Inc may not release information to the named individuals and or entities unless you identify them below.

Emergency Contact:
Name: _____ Relation: _____ Phone: (_____) _____-_____

Name: _____ Relation: _____ Phone: (_____) _____-_____

Name: _____ Relation: _____ Phone: (_____) _____-_____

Acknowledgement of Receipt of HIPAA Privacy

I understand that PrimeNet Medical Group Inc may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the notice of privacy practices for PrimeNet Medical Group Inc, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, I may contact the office at (954) 983-1220. I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment, or healthcare operations, but I also understand that the practice is not required to agree to a requested restriction.

Telehealth/Telemedicine Consent

I consent to use the use of telehealth/telemedicine in the provision of care and understand that I will be given information about tests, treatments, procedures and alternate choices for my medical care through the telehealth/telemedicine service.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**