



# PMG Research of Winston-Salem, LLC

## Medical Records Release Form

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### Authorization for Use and Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_  
Last First Middle/Maiden

Address: \_\_\_\_\_  
Street Address City State Zip Code

Date of Birth: \_\_\_\_\_

**Authorization:** I voluntarily authorize and direct PMG Research of Winston-Salem, LLC (“PMG”) to use and disclose my health information specified below to the following Primary Care Physician or Recipient:

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

Recipient’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

PMG may release information to these Family Members I authorize: \_\_\_\_\_  
\_\_\_\_\_

**Purpose or Need for Disclosure.** (check applicable categories).

- Further Health Care
- Insurance/Claims
- Application for Insurance
- Legal
- Personal
- Disability
- Academics
- Other: \_\_\_\_\_

**Information To Be Disclosed:** This Authorization permits PMG to disclose the following health information.  
**PLEASE INITIAL WHICH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE:**

- \_\_\_\_ All of the medical records that PMG has in its possession.
- \_\_\_\_ All of my medical records except for the following: \_\_\_\_\_
- \_\_\_\_ Only the following records or types of health information: \_\_\_\_\_

**Re-disclosure:** I understand that once PMG discloses my health information to the Physician or Recipient identified above, PMG cannot guarantee that the Physician or 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.

If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

\_\_\_\_\_ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment**, I hereby authorize the release of such information.

