Premier Wound Care & ID Specialist
250 Chateau Dr SW, Suite 115
Huntsville, AL 35803

PH: 256.533.4645
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MEDICAL RECORDS RELEASE

By signing this form, I authorize S. Paige Slater, CRNP, Premier Medical, LLC (dba Premier Wound Care and ID Specialist), and Scott D. Parker MD, LLC to obtain/release my confidential health information or a summary/narrative of my protected health information to or from other physicians or medical/healthcare facilities as necessary for efficient continuation of my care.

PATIENT NAME:_____Date of Birth:_____

The information you may obtain/release subject to my signature below is as follows (check all that apply):

___Complete Medical Records (check this box only if you agree to release ALL records, INCLUDING those itemized below)

___History and Physical **___Hospital Consults** **___Operative Reports**

___Radiology Reports **___Pathology Reports** **___Medication Record**

___Discharge Summary **___Office Notes**

___Lab reports to include:_____

FOR HIV PATIENTS ONLY:

___HIV related, including STDs (sexually transmitted diseases), Mental Health, Substance Abuse

Signature required: _____Date:_____

I understand that:

- **My right to healthcare treatment is not conditioned on this authorization**
- **I may cancel this authorization at any time**
- **If the person of facility receiving this information is a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.**
- **Release of HIV-related, STDs, mental health or substance abuse diagnosis and treatment information requires additional authorization**
- **There may be a charge for medical records**

Signature of Patient:_____Date:_____

Witness:_____Date:_____

Note: This authorization expires one year from date of above signature