Patient First®

Patient # _____

Center Name _____

Employee Release of Information Authorization

I, _____ [name of patient], authorize Patient First to release:

(i) my medical record from today's visit and from follow-up visits related to today's visit, in whole or in part, including all demographic, payment and other related information; and

(ii) such information from prior medical records to the extent requested or required to secure payment for today's visit and/or follow-up visits to:

_____ [name of employer], and to my employer's agents and insurers (including third party administrators and claims/case managers) and their respective agents and employees.

Full address of above-named employer: _____
Street Address City State

If Patient First determines that the above-named employer is not my employer, I authorize Patient First to use and release the above information in order to identify my true employer, and thereafter to release the above information to such employer and the other persons named above.

I understand that results of any laboratory, X-ray or other studies, including HIV test results (if any), along with a report on any other services performed, will be included on my medical record(s) and will be released pursuant to the foregoing authorization.

I understand that I will be required to pay for services described above unless I authorize Patient First to disclose the results of the services and related health information to my employer and the other persons named above.

I understand that if a pre-employment or other physical is required by my employer, it should not be considered a replacement for a periodic physical examination and testing by my Primary Care Physician.

Purpose of the requested use or disclosure of health information: At the request of the individual

Additional Rights and Required Disclosures. I understand that:

1. I have the right to revoke this Authorization at any time by notifying Patient First in writing at: Privacy Officer, Patient First Corporation, 5000 Cox Road, Glen Allen, Virginia 23060. Revocations are effective upon receipt and are not effective with respect to information disclosed prior to receipt.
2. After Patient First discloses the information described above, federal or state law may not protect it from further use or disclosure by the recipient.
3. I am entitled to receive a copy of this signed Authorization.

Expiration. This Authorization shall be in effect until I revoke it in writing or until the date that all claims related to the services described above are fully and finally adjudicated, subject to any shorter period specified by state law.

To keep our staff and patients safe during the COVID-19 outbreak, Patient First has modified its normal policy requiring a patient's signature on this form. Instead, you will receive a copy of this Authorization and be asked to agree to its terms before receiving services. If you agree, your Patient First provider will sign this form for you.

This section to be completed by Patient First staff:

Patient Name: _____ Date: _____

Patient or Guarantor reviewed and agreed to this Authorization before receiving services:

Print Provider's Name: _____ Provider's Signature: _____