



104 Sperryn Drive
Madison, AL 35758
(256) 772-4300
Fax (256) 772-4302

Patient Authorization to Release Medical Information

Patient Name (Print)

SS or Health Record Number

____/____/____
Patient DOB

_____ I authorize _____ to use or release/disclose my health information as described below.
Clinic/Doctor Name and Fax Number

Please identify the information to be released:

Please release my entire record

-OR-

Please release *only* the following information (check appropriate boxes and include other information where indicated):

Problem list

Medication list

List of allergies

Immunization records

Most recent history

Most recent discharge summary

Lab results (please describe the dates or types of lab tests you would like disclosed): _____

X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____

Consultation reports (please supply doctors' names): _____

Other (please describe): _____

The identified information will be used for the following purpose:

Changing Doctor

Moving

Individual Request

Physician Request

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____

Name: _____

Address: _____

Address: _____

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Patient Signature (or Signature of Person Completing Form if Not Patient*)

____/____/____
Date

*Relationship to patient: Parent Legal Guardian Other: _____

Distribution of copies: original to practice , copy to patient, copy to accompany information released