

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

## **Patient Authorization to Release Medical Information**

Please identify the information to be released:	Patient Name (Print)		SS or Health Record Number	Patient DOB
Please release my entire record -OR- Please release only the following information (check appropriate boxes and include other information where indicated): -Problem list	I authorize _		to use or release/disclose my heal	th information as described below
Please release my entire record -OR-   Please release only the following information (eheck 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):   The results (please describe the dates or types of x-rays or images you would like disclosed):   Consultation reports (please describe the dates or types of x-rays or images you would like disclosed):   Consultation reports (please describe)   Changing Doctor   Moving   Individual Request   Physician Request   Physician Request   Physician Request   Inderstand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency vins (HIV), It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.   Inderstand 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.   Inderstand 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 consteat a claim under my policy.   Inderstand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.   Name:	D1 '1 ''C 4 '		ax Number	
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