RELEASE FROM Alabama Pediatrics

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

SECTION A: I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / ____

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / ____

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / ____

PLEASE SEND THE INFORMATION TO:

Name: _____

Address: _____

_____

PHONE: _____

FAX: _____

PRACTICE PROVIDING INFORMATION:

Alabama Pediatrics

2815 Independence Drive

Birmingham, AL 35209

(205)879-7888

Section B:

1. Please send the (Circle one): Entire Medical Record Last 3 years Last 5 years

2. Other limitations (specify): _____

Section C: Patient Rights and Signature

I understand that my records may contain information regarding all diagnoses made and treatments received at Alabama Pediatrics and may include confidential information about the diagnosis and treatment of conditions such as but not limited to HIV/AIDS, STDs, drug and alcohol abuse, and psychological conditions. I give specific authorization for these records to be released. I understand that my signature on this form is voluntary. I may revoke this authorization at any time by writing to Alabama Pediatrics at the address indicated above. I understand that once the health information that I have authorized to be disclosed is released or sent to the indicated recipient, that other persons or organizations may re-disclose it, at which time the information may no longer be protected under privacy laws. A photocopy of this authorization (with signature) is to be considered as valid as the signed original document. I understand that I must provide proof of identify at the time of signature. This authorization is valid for TWO YEARS unless another duration is specified under section B (part 2).

_____

_____

Signature of patient or patient's representative DATE

PRINTED NAME OF PATIENT REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

Alabama Pediatrics

2815 Independence Drive Birmingham, AL 35209
Phone (205) 879-7888 Fax (205) 879-6822