Alabama Pediatrics

HIPAA Authorization for Release of Information

Section A : Name and Locations

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:**____/____/____

_____ **Date of Birth:**____/____/____

_____ **Date of Birth:**____/____/____

Please send the information to:

Alabama Pediatrics
2815 Independence Drive
Birmingham, Alabama 35209
205-879-7888

Please Fax to:
205.879.0822

Practice providing information:

_____
Name

_____
Street

_____
City, State, Zip code
Telephone _____
Fax _____

Section B: Must be completed for all authorizations

1. Please send the: ___Entire medical record. ___Last 3 years ___Last 5 years

2. Other limitations (please specify, if any):_____

3. Purpose of disclosing the information: __Insurance __Attorney__Doctor__Personal___Moving

Section C: Patients rights and signature

I understand that my records may contain information regarding the diagnosis and treatment of all my medical conditions in the possession of the practice indicated above and may include confidential information such as that about the diagnosis of treatment of conditions such as HIV/AIDS, STDS, drug/and or alcohol abuse and psychological conditions. I give my specific authorization for these records to be released. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization at any time by writing to the medical practice at the address indicated above. I understand that once the health information that I have authorized to be disclosed reaches the indicated recipient, that other persons or organizations my re-disclose it, at which time may no longer be protected under Privacy Laws. A photocopy of this authorization is to be considered as valid as the signed original document. I understand that I must provide proof of identity at the time of signature.

_____ ____/____/____

Signature of patient or patient's representative **Date**

THIS AUTHORIZATION IS VALID FOR (5) YEARS UNLESS ANOTHER DURATION IS SPECIFIED UNDER SECTION B(2).

Printed name of patients representative:_____

Relationship to the patient:_____