Alabama Clinics

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or 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 healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient: _____

Social Security # _____

Date of Birth: _____

Person/Organization Providing Information: _____

Providing Person/Organization Fax Number _____

Person/Organization Receiving Information: _____

Receiving Person/Organization Fax Number _____

Specific description of information: _____

What is the purpose of the use or disclosure? _____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

I understand that this authorization will expire on _____ (MM/DD/YY)

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions they took before receiving the revocation.

_____ _____

Signature of Patient or Guardian | Date Signed

_____ _____

Printed Name of Patient or Guardian | Relationship to patient