South Alabama
MEDICAL CLINIC

AUTHORIZATION FORM-RELEASE OF MEDICAL RECORDS

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____ Social Security #:_____

BY SIGNING THIS AUTHORIZATION FORM, I UNDERSTAND I AM GIVING MY AUTHORIZATION TO:

_____

TO RELEASE MY PROTECTED HEALTH INFORMATION INCLUDING MEDICAL, PSYCHIATRIC, ALCOHOL, HIV, DRUG ABUSE, AND/OR FINANCIAL INFORMATION CONTAINED IN MY RECORDS TO:

SOUTH ALABAMA MEDICAL CLINIC

10075 GRAND BAY WILMER RD

GRAND BAY, AL 36541

251-865-1852-PHONE 251-865-1854 FAX

PURPOSE OF RELEASE: AT THE REQUEST OF THE INDIVIDUAL: YES OR NO OTHER REASON: _____

INFORMATION RELEASED: _____

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME EXCEPT TO THE EXTENT THAT ANY ACTIONS HAVE BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. I CAN REVOKE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REQUEST TO THE RELEASE OF INFORMATION DEPARTMENT OF:

_____

THIS AUTHORIZATION WILL EXPIRE IN 1 YEAR FROM THE DATE OF SIGNING BELOW UNLESS SPECIFIED OTHERWISE.

DATE OF EXPIRATION IF DIFFERENT: _____

I UNDERSTAND THTAT THE STATED RECIPIENT MAY NOT BE SUBJECT TO PRIVACY LAW AND THAT MY PROTECTED HEALTH INFORMATION MAY FURTHER DISCLOSE WITHOUR PRIVACY REGULATION PROTECTION:

I UNDERSTAND THAT I AM NOT REQUIRED TO SIGN THIS FORM IN ORDER TO RECEIVE TREATMENT FROM:

SOUTH ALABAMA MEDICAL CLINIC

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE DATE

_____ _____

SIGNATURE OF WITNESS DATE