INTERNAL MEDICINE CENTER, LLC
Established 1946
101 Memorial Hospital Drive, Suite 200, Mobile, AL 36608 P.O. Drawer 160928, Mobile, AL 36616
www.internalmedicinecenter.org 251-414-5900

Request for Release of Information

Patient Name:_____
Last First MI Maiden (Please include all names by which the patient has been known)

Date of Birth:_____/_____/_____ S.S.N.:_____ Medical Record #:_____

I Hereby Authorize Internal Medicine Center, LLC

To Release To:_____**OR** To Obtain From:_____

At this Address:_____

Phone:_____ Fax:_____

PURPOSE FOR RELEASE:

___Legal ___Insurance ___Evaluation & Treatment Other:_____

TYPE OR CATEGORY OF MEDICAL INFORMATION TO BE RELEASED
(Example: Office Notes, Labs, In-Office Testing, all records)

_____

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1. I understand that the above request may contain information concerning sexually transmitted disease and/or treatment, drug and/or alcohol test and treatment, psychiatric treatment, and HIV / AIDS tests or treatment

   I AM SPECIFICALLY PERMITTING Internal Medicine Center, LLC to include this information in the records release.

   _____ _____
   Signature of Patient *Date*

   I AM SPECIFICALLY *NOT* PERMITTING Internal Medicine Center, LLC to include this information in the records release.

   _____ _____
   Signature of Patient *Date*

2. I understand this authorization may be revoked in writing at any time by submitting a letter to the medical records supervisor, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed below.

   The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law

   I acknowledge that I have read and fully understand this authorization as it applies to me. By my signature, I authorize the execution of the terms of this document.

   _____ _____
   Signature of Patient / Legal Representative *Date*

   As a legal representative, I have the authority to act for the individual because I am:_____

   _____ _____
   Witness *Date*