

## 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 Alabama Medical Group, P.C.**

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)

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** Alabama Medical Group, P.C. to include this information in the records release.

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

**I AM SPECIFICALLY NOT PERMITTING** Alabama Medical Group, P.C. 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: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Employee/Witness*

\_\_\_\_\_  
*Date*