AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient name:_____ Date of birth:_____

Medical record number or SSN:_____

The following person or entity is authorized to disclose my medical records:

OB-Gyn Associates of Alabama P.C.
St. Vincent's North Tower
800 St. Vincent's Drive Ste.600
Birmingham, Alabama 35205
Phone: (205) 271-1600 Fax (205) 271-3167

The disclosure will be made to the following person or entity:

_____ Phone:_____
_____
_____ Fax:_____

The type of information to be used or disclosed:

( ) List of medications and or allergies
( ) Most recent history and physical
( ) Most recent discharge summary
( ) Laboratory results
( ) Entire Records
( ) Problem list
( ) Immunization record
( ) Consultation reports
( ) X-ray and imaging reports
( ) OTHER_____

( ) From date: _____ To date: _____

I herby authorize the use or disclosure of information about the above named individual and I understand that:

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire it will expire on the following date_/_/__, event or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
6. By signing below, I recognize that he 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.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness