William B. Herron, M.D
Frank Wang, M.D.
Steven P. Wittmer, M.D.
Chad D. Reaves, D.O.
Kimberly Nolte, CRNP

188 Hospital Dr., Suite 402
Fairhope, Alabama 36532
Phone (251) 990-1740
Fax (251) 990-1831

Authorization for Release of Records

Patient name:_____DOB:_____

*By signing this authorization, I authorize **(_____)** to use and/or disclose protected health information **(PHI)**, which may include, but is not limited to the release of medical, psychological, psychiatric, alcohol, drug abuse, and HIV/AIDS information me to or for the party listed below.*

This authorization permits_____to use and disclose to:

Doctors name:_____

Fax number:_____

Address:_____

For the Purpose of:_____

The following individually identifiable health information may be released:

__ *Specific dates: _____*	__ *Prior 12 months*	__ *All dates*
__ *Office Records*	__ *Lab Results*	__ *X-ray reports*
__ *EKG's*	__ *Consultations*	__ ***ALL records***
__ *Other test results*	__ *Hospital Admission*	__ *Other _____*

This authorization will expire on_____.

*When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **(_____)** has acted in reliance upon this authorization. My written revocation must be submitted to the clinic's above address- attention Privacy Officer.*

_____ _____

Printed name of patient or Legal Guardian **Signature of Patient or Legal Guardian**

Date_____ **Witness_____**