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Authorization form - Release of Medical Records
For use and disclosure of Protected Health Information

Patient name: _____ DOB: _____

Social Security Number: _____

*By signing this authorization, I authorize **(Fairhope Internal Medicine)** 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 about me to or for the party listed below.*

This authorization permits *Fairhope Internal Medicine:* ☐ TO REQUEST RECORDS FROM ☐ TO RELEASE RECORDS TO

DR'S NAME & OR FACILITY NAME - _____

_____

PHONE # - _____ FAX # - _____

Charges according to Alabama Law:
- $5 Retrieval Fee
- $1 per 1st 25 pages
- $.50 per page thereafter

For the Purpose of: _____

The following individually identifiable health information may be released:

☐ *Specific dates:* _____ ☐ *Prior 12 months* ☐ *All dates*
☐ Office notes ☐ Lab results ☐ X-ray *reports*
☐ EKG's ☐ Consultations ☐ *ALL* records
☐ Other test results ☐ Hospital admission ☐ other _____

This authorization will expire on 1 YEAR FROM DATE FAXED

*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 HIPPA Privacy Rule, I have the right to revoke this authorization in writing except to the extent that **Fairhope Internal Medicine** has acted in reliance upon this authorization. My written revocation must be submitted to the clinics above address - attention Privacy Officer.*

_____ _____
Print name of patient or Legal Guardian Signature of Patient or Legal Guardian

_____ _____
Date Witness