

Frank Wang, M.D

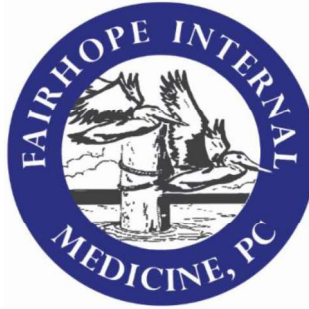
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**Authorization form - Release of Medical Records
For use and disclosure of Protected Health Information**

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:

<i>Specific dates:</i> _____	<i>Prior 12 months</i>	<i>All dates</i>
Office notes	Lab results	X-ray <u>reports</u>
EKG's	Consultations	<u>ALL</u> 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