

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

Patient:

Specify any other names the patient may have used: _____

Address: _____

Date of Birth: _____ SSN: _____

Dates of Service: From: _____ To: _____

Southern Records Management Corp, acting as an agent of Physicians Medical Center Carraway, is hereby authorized to release any and all information, records and copies requested below on the above named patient regarding any care and treatment given during the Dates of Service shown above to:

Requesting Party: _____

Address: _____

Purpose: _____

The following information is requested for release:

_____ Unless initialed by Authorizing Party, information regarding Psychiatric Care and Drug/Alcohol **will not** be released.

_____ Unless initialed by Authorizing Party, information regarding Blood Tests for HIV **will not** be released.

- | | | | |
|--------------------------|-------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | Admission Form | <input type="checkbox"/> | Progress Notes |
| <input type="checkbox"/> | Discharge Summary | <input type="checkbox"/> | Physician Orders |
| <input type="checkbox"/> | History & Physical | <input type="checkbox"/> | Nursing Notes |
| <input type="checkbox"/> | Consultation(s) | <input type="checkbox"/> | Medication Administration Records |
| <input type="checkbox"/> | Operative Report | <input type="checkbox"/> | Respiratory Records |
| <input type="checkbox"/> | Pathology Report | <input type="checkbox"/> | Physical Therapy Records |
| <input type="checkbox"/> | Xray Reports | <input type="checkbox"/> | Emergency Room Record |
| <input type="checkbox"/> | Laboratory Results | <input type="checkbox"/> | Outpatient Record |
| <input type="checkbox"/> | EKGs | <input type="checkbox"/> | Entire Health Record |
| <input type="checkbox"/> | Other (Describe): _____ | | |

Any copies provided will be at the expense of the Requesting Party. I understand that my records are protected by federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The above provider and its agent are not responsible for any information re-disclosed by the recipient to whom the information is furnished under a valid authorization. I understand that this Authorization is revocable until the request has been fulfilled at which time the authorization expires. Written revocations are to be sent to Physicians Medical Center Carraway, 1600 Carraway Boulevard, Birmingham, Alabama 35234, and a copy mailed to its agent, Southern Records Management Corp, 560 Arba Street, Montgomery, Alabama 36104. I understand that a revocation is not effective to the extent that the provider or its agent have already relied on this authorization for the use or disclosure of the information..

Authorizing Party

Witness

Date

Date

If the Authorizing Party is not the patient, please specify the relationship to the Patient and provide documentation of any legal authority to act for the patient.
