ALBERTVILLE
PRIMARY CARE

Authorization to Release Protect Health Information

Office: 256.840.6380
Fax: 256.849.0693

Please Print

Patient Name: _____ **Date of Birth** ____ / ____ / _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____

Release Information from Albertville Primary Care to:

Name / Facility: _____ **Attention:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Purpose of Request: □ Personal □ Treatment □ Legal □ Insurance □ Transfer
□ Other: _____

Release Information to Albertville Primary Care from: Please Fax to 256.849.0693

Name / Facility: _____ **Fax Number:** _____

Date Range: _____

□ Progress Notes □ Radiology Reports □ Labs □ Operative Reports □ Injections

□ Physical Therapy □ EMG Report □ Work Status □Radiology Disk □ Billing Statement

□ Other: _____

Release Information to Albertville Primary Care from: Please Fax to 256.849.0693

I understand that: I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____ (Please Initial)

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, if will not have any effect on any actions taken prior to receiving the revocation.
- ✓ Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
  If I do not specify expiration this authorization will not expire.
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

Signature*: _____ **Today's Date:** ____ / ____ / _____

**For non-emancipated minors under the age of 19 years, a parent or guardian must sign release form. If patient is unable to sign a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*