

1643 Slaughter Rd. Madison, AL 35758
(256) 895-8148

Patients' Name _____ DOB: _____ SS# _____

I, the undersigned authorize _____ to request/release the following specific patient information:

Format of information:

_____ both verbally and in writing _____ only verbally _____ only in written form

Description of individually identifiable health information (initial appropriate type(s) of information) to be released/exchanged/obtained:

- _____ Psychiatric Progress Notes: Inclusive Dates _____ to _____
- _____ Psychiatric Assessment _____ Physical Examination
- _____ Treatment Plan(s) _____ EEG results
- _____ Medications Prescribed _____ EKG results
- _____ Laboratory Values and Vital Signs _____ Growth Chart
- _____ Medical and or Psychiatric Diagnosis _____ Immunization Record
- _____ All records relating to a Disability claim
- _____ Medical Progress Notes: Inclusive Dates _____ to _____
- _____ Hospital or ER Admission and Discharge Summaries: Inclusive Dates _____ to _____
- _____ Clinical records used to make benefit determinations (may include HIV/AIDS and/or Substance Abuse information)
- _____ Medical Letter and or Statement for _____
- _____ Other (describe): _____

This information is to be release to/from and/or obtain information from:

Name: _____
Address: _____
Phone Number: (_____) _____ Fax (____) _____

The purpose of this release is (check all that applies):

- _____ To support the clinically appropriate management and coordination of my medical, mental health, and/or substance abuse treatment.
- _____ Other (describe): _____

This Authorization is valid for the period of one year from the date listed below. The patient signature listed below may revoke this authorization at any time and may refuse to sign the authorization. Upon signature, the patient will be provided a copy of this authorization. The information disclosed pursuant to this authorization will not be subject to re-disclosure by the recipient and will be covered by the federal Privacy Rules. The patients' eligibility for benefit, condition of treatment, payment or enrollment in any health plan will not be affected by this authorization. This authorization conforms to 45CFR - Parts 160 and 164, Dec. 28 2000.

Patient Signature Date: _____

Parent (if under 14)/ Patient Representative Signature Printed Name and relationship to Patient Date: _____

Witness Date: _____