HOOVER FAMILY MEDICINE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

From (Releasing Facility)

Facility Name _____

Address _____

City _____

State & ZIP _____

Telephone _____ Fax _____

To (Receiving Facility)

Hoover Family Medicine

~~**1575 Montgomery Highway**~~ 3081 Lorna Road, Suite 101

Hoover, AL 35216

(205) 979-3381 **(205) 979-3726 fax**

Patient Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Medical Record Number: _____

Address: _____ Telephone: _____

_____

_____

Please release the following medical/health information:

□ Complete Medical Record □ Radiology (x-rays, MRI, CT) □ Other (please specify) _____

□ Clinic Notes □ Ultrasound _____

□ Laboratory Reports □ Billing/Accounting _____

Dates of care from _____ to _____

The information released may be used for the following purpose: _____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I hereby release the Receiving Facility and the Releasing Facility from any liability related to the release, use, or disclosure of this information as described herein.

I understand that I may revoke this authorization at any time, and unless expressed otherwise, this authorization shall expire six months from the date of my signature below.

Patient signature _____ Date _____

Witness Signature _____ Date _____

Expiration Date _____ (If not indicated, expires six months from date signed by patient.)