Powell Orthopedics & Sports Medicine
Authorization to Disclose Health Information
2020 Canyon Road
Suite 200
Vestavia Hills, AL 35216
Phone: (205)877-9191
Fax: (205) 877-8377
TAX ID: 273656203

_____ _____

Patient Name (Print Name) SSN or Medical Record Number

_____

Patient DOB

I authorize_____to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record Phone: _____

-OR- Fax: _____

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Office notes
- ☐ X-ray and Imaging Reports
- ☐ Medication list
- ☐ Lab results
- ☐ History & Physical
- ☐ Operative note
- ☐ Other (please describe):_____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating 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 understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and regulations.

_____I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on the following date __/__/__. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Phone: _____

Address: _____ Fax: _____

Signature of Patient or Legal Representative_____

If signed by Legal Representative, Relationship to Patient: _____

Witness Signature: _____

Date:_____