Cullman Internal Medicine

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Authorization for Medical Records Release

Patient Name:	(Please Print)
Date of Birth :	
Date Request Received:	Date of Expiration:
Persons/Place providing the informati	on:
Phone #	Fax# :
Persons/Place receiving the information	on:
Specific description of information (in	cluding date(s)):
Purpose of use or disclosure:	
authorization at any time by notifying the	re must read and initial the following statements: I understand that I may revoke this Cullman Internal Medicine Privacy Officer in writing, but if I do, it will not have any dicine took before they received the revocation.
I hereby authorize the use of disclosure of this authorization is voluntary. I understar health care provider, the released inform I understand that Cullman Internal Medici	my individually identifiable health information as described above. I understand that id that if the organization authorized to receive the information is not a health plan or ation may no longer be protected by federal privacy regulations. ne may not condition the provision of treatment, payment, enrollment in a health is authorization, except under the following circumstances:
 research. Initial enrollment in health plans make eligibility determinations. Furnish healthcare services to m 	s can be conditioned on my signing an authorization to use and disclose PHI in the can be conditioned on signing an authorization for the health plan in review PHI to e at the request of a third party can be conditioned on me signing an authorization hird party requesting the treatment.
Initials:	
Signature of patient or patient's repre	sentative:
Printed name of patient or patient's re	epresentative:
Relationship to Patient:	Date signed:
Doctory	