United Doctors
Family Medical Center

Dr. Angela Clifton♦Dr. Enrico Gaspar ♦ Dr. Alvin Tenchavez
Ashley Lackey, CRNP♦Miranda Smith, CRNP
2986 US HWY 431Boaz, Al 35957
Mailing: P.O. Box 697 Boaz, Al 35957
256-840-8181 ♦ FAX 256-744-8282

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____/_____/_____
Address: _____ SSN: _____/_____/_____
City/State/Zip: _____
Phone: (_____) _____

☐ I authorize United Doctors Family Medical Center, LLC to release information to:

_____
Name of Agency (Doctors office/Hospital/etc.) to Receive Information

_____
Address

_____
City/State/Zip

_____
Phone/Fax

☐ I authorize United Doctors Family Medical Center, LLC to obtain information from:

_____
Name of Agency (Doctors office/Hospital/etc.) to Receive Information

_____
Address

_____
City/State/Zip

_____
Phone/Fax

RECORDS REQUESTED:

☐ ALL RECORDS ☐ boratory/Pathology Reports Pharmac☐rescription Records

☐&P/ DC Summary X☐y/ Radiology Reports ☐ Billing Records

☐ Other: _____

This authorization of release/request is valid for one (1) year from the date of the signature, unless otherwise noted. I understand this authorization can be revoked by sending a request in writing to the Privacy Officer at the above stated address. The revocation will not apply to information that has already been released or obtained in response to this authorization. I understand by signing this release I authorize United Doctors Family Medical Center to provide the above stated entity with the information requested. I am aware there is a charge for obtaining medical records if requested by an individual.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:
_____

☐ Copy of legal representative papers obtained and attached

_____ _____
UDFMC Witness Date