**Primary Care Internists of Montgomery Authorization to Release Medical Information**
**1722 Pine Street, Suite 309, Montgomery, AL 36106**
**334-262-0342 Phone 334-262-0390 Fax**

_____ _____ _____/_____/_____
Patient Name (Print) SS Number Patient DOB

_____ I authorize Primary Care Internists of Montgomery to use or release/disclose my health information as described below.

_____ I authorize another provider to use or release/disclose my health information as described below.

Other provider (Name and address): _____

_____

Please identify the information to be released:

☐ Please release my entire record

-OR-

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

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):_____
  _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
  _____
- ☐ Consultation reports (please supply doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other health care providers as needed
☐ 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 below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or 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.

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

Name: _____ Name: _____

Address: _____ Address: _____

This authorization will expire on (insert date or event): _____
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.

_____ _____/_____/_____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____/_____/_____
Witness Signature Date