Infirmary Surgical Specialists
INFIRMARY HEALTH

Authorization Form – Release of Medical Records
For use and disclosure of protected Health Information

Patient Name: _____ Date of Birth: ____/____/_____
Social Security Number: _____ - ____ - _____

By signing this Authorization Form, I understand I am giving my authorization to:
_____, medical record custodian, to release my protected health information including Medical, Psychiatric, Alcohol, HIV, Drug Abuse and/or Financial Information contained in my records to:
Name of person or organization: _____

Address: _____

Phone Number: _____ Fax Number: _____
(Please use additional form for additional persons or organization)

Purpose of release: At the request of the individual: _____
Other reason: _____

Diagnostic Test: _____ Release to patient: _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to: Infirmary Surgical Specialists, Release of Information Department, 3 Mobile Infirmary circle, Suite 305, Mobile, AL 36607.
This authorization will expire in 1 year from the date of signing below unless specified otherwise.
Date of expiration if different: _____
I understand that the stated recipient may not be subject to privacy laws and that my protected health information may be further disclosed without privacy regulation protection.
I understand that I am not required to sign this form in order to receive treatment from Infirmary Surgical Specialists.

_____ _____
(Signature of Patient) ***Date***

_____ _____
(Signature of Authorized Representative) ***Date***

_____ _____
(Signature of Witness) ***Date***