

CULLMAN INTERNAL MEDICINE, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose to the use and disclosure:

Please list the family members or others persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and /or reference to any mental or nervous disorders, drug, an/or alcohol abuse, or sexually transmitted disease.

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis ONLY in an emergency situation:

_____ Relationship: _____

_____ Relationship: _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Patient Signature or Personal Representative

Date

As a personal representative, I have authority to act for the individual because I am: _____

Cullman Internal Medicine
1890 Al Hwy 157 Suite 300
Cullman, Al 35058
256-737-8030 Fax: 256-737-8058

Authorization for Medical Records Release

Patient Name: _____(Please Print)

Date of Birth : _____

Date Request Received: _____ Date of Expiration: _____

Persons/Place providing the information: _____

Phone # _____ Fax# : _____

Persons/Place receiving the information: _____

Specific description of information (including date(s)): _____

Purpose of use or disclosure: _____

The patient or the patient’s representative must read and initial the following statements: I understand that I may revoke this authorization at any time by notifying the Cullman Internal Medicine Privacy Officer in writing, but if I do, it will not have any effect on any actions Cullman Internal Medicine took before they received the revocation.

Initials: _____

I hereby authorize the use of disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that Cullman Internal Medicine may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on signing this authorization, except under the following circumstances:

- Participating in research projects can be conditioned on my signing an authorization to use and disclose PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an authorization for the health plan in review PHI to make eligibility determinations.
- Furnish healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

Initials: _____

Signature of patient or patient’s representative: _____

Printed name of patient or patient’s representative: _____

Relationship to Patient: _____

Date signed: _____

Doctor: _____