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:_____