Alabama Heart and Vascular Medicine
100 Rice Mine Road Loop, Suite 104
Tuscaloosa, AL 35406
Phone: (205) 561-2370   Fax: (205) 345-4921

Authorization to Release or Obtain Medical Information

Patient Name (print): ___________________________________ DOB: _____/_____/_____
Address: ____Phone: _________________
City: _______________________State: ______________ Zip: ____________________
Social Security Number: ____

I, the undersigned, authorize and request **Alabama Heart and Vascular Medicine to ____ release to ____ obtain from the following:**
Physician/Organization/Individual(s): ____
Address: _____________________________ Phone: _________________ Fax: ______________
City: ______________________________ State: _______________ Zip: ______________

Please identify the information to be released/obtained:
___ Complete record
___ Lab result (please describe dates or types of lab tests requested): __________________
___ X-ray and Imaging results (please describe dates or types of x-rays or images requested)
____
___ Progress Notes
___ Other (please describe) ____

The identified information will be used for the following purposes:
____ My personal records ____ Sharing with other healthcare providers as needed
____ Moving ____ 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 STD's, AIDS, or HIV. It may also include information relating to behavioral or mental health services, and treatment for drug and alcohol abuse.
_____ When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing and understand my 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.

Patient Signature: _______________________________________ Date: _____/_____/_____
Patient Signature (or signature of person completing form if not patient)

Relationship to Patient: _____ Parent _____ Legal Guardian ____ Other _________________

Witness Signature: _______________________________________ Date: _____/_____/_____

This authorization will expire on (insert date or event): __________________________________
If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.