Cancer Surgery of Mobile
Mobile | 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: ______________________________

Street Address: ______________________________

City, State, and Zip Code: ______________________________

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 the ________________________ *(clinic name) Release of Information Department.*

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 __________________________ (name of clinic).

______________________________ ________________
(Signature of Patient) (Date)

______________________________ ________________
(Signature of Authorized Representative) (Date)

______________________________ ________________
(Signature of Witness) (Date)