**Fairhope Family Medicine, LLC**

**21875 Highway 181**

**Fairhope, AL 36532**

**Phone: 251.928.1442 Fax: 251.210.0969**

**Authorization for Release of Medical Record Information**

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_ Telephone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I hereby authorize:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to disclose information from my / my minor child's medical records to:

Fairhope Family Medicine Phone 251-928-1442

21875 Highway 181 Fax 251-210-0969

Fairhope, AL 36532

I authorize the above entity/person to disclose the information requested by Fairhope Family Medicine, LLC representatives as indicated below. I understand that portions of my record may have extra protection under Alabama or federal law, including information relating to mental health, alcohol or substance abuse, developmental disabilities and HIV status or test results. However, if any such information is included in the information held by the entity/person identified above, I hereby authorize the disclosure of that information.

The specific information I wish to have released is:

\_\_ Discharge Summary \_\_ History & Physical \_\_ Progress Notes \_\_ Operative Notes \_\_ Pathology Reports

\_\_ Lab Reports \_\_ Radiology Reports \_\_ EKG/ECHO/Cardiac Cath \_\_ Emergency Reports

\_\_ All Records \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(include dates of treatment)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NO ELECTRONIC MEDIA PLEASE (i.e disks or usb drive).

THIS REQUEST IS SENT AS A COURTESY TO OUR PATIENT AT THE PATIENT’S REQUEST AND ANY COSTS DUE FOR COPIES MUST BE BILLED TO THE PATIENT AND NOT FAIRHOPE FAMILY MEDICINE

This information is needed for the following reason:

\_\_ Transfer of Care \_\_ Continuation of Care \_\_ Payment of Claim(s) \_\_ Coordination of Benefits

\_\_ Other (specify) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that I may revoke this consent, in writing, at any time, except where information has already been released. I am aware that the withdrawal is not effective until received by Fairhope Family Medicine.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: (Parent or Legal Guardian if Minor Child) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: |

This authorization is valid for a ninety (90) day period from the date it is signed.

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_