OB-GYN Associates of Montgomery, P.C.
495 Taylor Road
Montgomery, Alabama 36117
Phone # (334) 279-9333 Fax # (334) 279-9057

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____

City: _____ State: _____ Zip: _____ hereby authorize:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY OR OTHER HEALTHCARE PROVIDER)

Address: _____City: _____State: _____Zip: _____

To disclose/release my medical information to:

Name: _____

Address: _____City: _____State: _____Zip: _____

For the purpose of: _____

Medical Information to be delivered by: ☐ Mail ☐ Fax ☐ Pick up

My authorization extends only to those data elements/documents **INITIALED** below:

_____ Statements of charges or payment
_____ Records of visits (all visits)
_____ Record of visit for a specific date or dates (please specify) _____
_____ Aids, HIV, Mental Health, Substance Abuse
_____ All of the above
_____ Other (must be specific) _____
_____ Lab reports
_____ Hospital

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. OB-GYN Associates of Montgomery, P.C., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
(PATIENT'S NAME PRINTED) DATE

_____ _____
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM DATE ABOVE)

_____ _____
SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES) WITNESS

***The most recent year of the patient record is copied as a courtesy, otherwise, the patient may be charged a fee for the copies set forth in the following schedule:
$5.00 for research and retrieval, $1.00 per page for the first 25 pages, and $.50 per page for each additional page.
Records are copied in house; therefore you may receive a bill/invoice before records are released.