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

(PLEASE ALLOW 2-4 WEEKS FOR REQUEST TO BE PROCESSED)

I, _____/_____ who resides at _____
(PATIENT'S FULL NAME) (DATE OF BIRTH)

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: _____

Reason for request: _____

Medical Information to be delivered by: ☐ Mail _____ ☐ Fax #_____ ☐ Pick up
(PATIENT'S INITIALS)

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

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

(All below are Sensitive Protected Health Information)
_____ Mental Health
_____ Substance Abuse
_____ Aids, HIV, Sexually Transmitted Diseases (STD)

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. I understand that any disclosure of healthcare information carries with it potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about my disclosures of my health information, I can contact my provider of care.

_____ _____
PATIENT'S NAME PRINTED DATE

_____ _____
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) EXPIRATION DATE (IF OTHER THAN 1 YEAR FROM DATE ABOVE)

_____/_____ _____
DATE OF BIRTH LAST 4 DIGITS OF SOC SEC # 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: $10.00 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.