890 N Dean Rd, Ste 500, Auburn, AL 36830 * Phone: 334-821-2708 * Fax: 334-821-3309
Dr. Brian Wood * Dr. Michael Canfield

AUTHORIZATION TO DISCLOSE / RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act of 1195 (HIPAA), governing the use and disclosure of Protected Health Information (PHI)

I hereby authorize Primary Medicine Associates to _____ Disclose/ Release to _____ Obtain From

____________________ ____________________ ____________________
Name of Person or Organization Telephone Fax

____________________ ____________________ __________ __________
Address City State Zip

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing the the Privacy Officer. Unless revoked, this authorization will expire three months for date of signature or on the following date: ________________

If I choose to limit the information released, I understand Primary Medicine Associates (PMA) may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by PMA. PMA and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized.

_____ PARTIAL medical records; please specify parts and dates to be released: ____________________________

____Progress Notes ____ Immunizations ____ Xray Reports ____ Allergy

____Lab Report ____ Physical ____ GYN Report ____ Consultation

_____ Other: ____

_____ ALL medical records without exception; including all lab testing (HIV) and mental health treatment.

For the purpose of: ____

I authorize the release of my medical records as indicated above.

____
Signature of patient or legal guardian Date

____
Printed Name Date of Birth

____
Address City, State Zip

____
Telephone Number Social Security Number

____
Witness Date

Note to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Laws (including HIPPA) and prohibits you from further disclosure without written consent of the person to whom it pertains. Charges may apply for copies of medical records.

_____ **Faxed** _____ **Copies Left for pt** _____ **Mailed** **Date** ____________________________