1841 Glynwood Drive, Prattville, AL 36066
Phone: 334-568-5025 Fax: 334-568-5021

Authorization for Disclosure of Health Information

Patient Name: ____

Date of Birth: ______________________ Phone: ________________________________

Address: ____________________________ City: _________________ Zip: ____________

I authorize the use or disclosure of the above-named individual's health information as described below, by:
Magnolia Family Practice

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

- Complete Health Records
- Medical Exam
- Immunization record
- Lab results / X-ray reports
- Consultation reports
- Other (Please specify): _______________

Name of Medical Facility that provided care:

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in **365 days**. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

____ ______________________
Signature of participant or representative Date

____________________________________ ____
Name of Patient or Representative Description of personal representative's authority