



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).

- | | |
|--|--|
| <input type="checkbox"/> Complete Health Records | <input type="checkbox"/> Lab results / X-ray reports |
| <input type="checkbox"/> Medical Exam | <input type="checkbox"/> Consultation reports |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Other (Please specify): _____ |

Name of Medical Facility that provided care:

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