
**1841 Glynwood Drive**
**Prattville, AL 36066**
**Phone: 334-568-5025**
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## Authorization for Disclosure of Health Information

**Patient name:** _____

**Date of birth:** _____ **Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **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
_____ Other (please specify): _____

_____ Lab results/X-ray reports
_____ Consultation reports

**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**