OBSTETRICS & GYNECOLOGY OF WEST ALABAMA, P.C.

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RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

**********We do not accept electronic fax**********

I,_____, date of birth:_____, authorize release of my medical/health information to the Receiving Facility by the Releasing Facility as indicated below:

To:	**From:**
Facility Name:	Facility Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Telephone number:	Telephone number:
FAX number:	FAX number:

Specific description of information (including dates)_____

What is the purpose of this disclosure?_____

I authorize the provider to release copies of my medical confidential health information in the following manner:

_____Mail _____FAX _____To be picked up

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations. I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. I understand that this authorization will expire on _____(day, month and year). I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient representative:_____
Date:_____
Printed name of patient or patient's representative:_____
Relationship to patient:_____

You may refuse to sign this authorization.