INRI MEDICAL ASSOCIATES P.C. d/b/a Northside Medical Associates Patient Authorization Disclosure for Protected Health Information

MEDICAL RELEASE FORM

Patient Name: ____ DOB: ________________ Phone: ______________________________

Patient Address: ______________________________________ City: _________________ State: __________ Zip: ______________

I hereby authorize:

Doctor/ Clinic Name: ____ Phone: _____________________________

Address: ____ Fax: ________________________________

To release all records to:

Doctor/ Clinic Name: ____ Phone: _____________________________

Address: ____ Fax: ________________________________

Specific description of health information to be disclosed IF other than complete records (dates of service, and type of service, etc.)

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This information is to be disclosed for the following purpose: ____

By providing this Authorization, I understand the following:

A. I understand that this health information may include information regarding drug and alcohol, human immunodeficiency virus test results and psychotherapy notes.

B. I understand that this Authorization is voluntary, I may refuse to sign this Authorization and my treatment or payment obligation will not be affected.

C. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules.

D. I understand that I have the right to revoke this Authorization at any time by notifying INRI MEDICAL ASSOCIATES P.C. d/b/a Northside Medical Associates in writing, but if I do, it will not have any effect of the uses or disclosures prior to the receipt of the revocation.

E. I understand that upon this request, I may receive a copy of this Authorization form after I sign it.

F. I understand that this Authorization will expire on ___/___/___. If left blank, expiration date will be one year from the date of signature.

G. I understand that my records will be provided to me in electronic format (CD) and that is if I wish to have it in paper format that I should initial here __________ (If left blank it is understood that you wish to have your record in electronic form).

Patient or Patient Representative's Signature Date

____ ____

Printed Name of Patient Representative's (if applicable) Relationship to patient (if applicable)

____ ____

ADDRESS TO SEND RECORDS To: 70 Plaza Drive, Pell City, AL 35125

PHONE: 205-814-9284 MAIN FAX: 1-855-332-0432