MARSHALL
FAMILY MEDICINE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PHONE: 256-571-8500

FAX: 256-571-8502

Please Print

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information From Marshall Family Medicine To:

Name / Facility: _____ **Attention:** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other: _____

Release Information To Marshall Family Medicine From: PLEASE FAX TO 256-571-8502

Released From: _____ **Fax Number:** _____

Date Range: _____

☐ Progress Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Injections ☐ Physical Therapy

☐ EMG Report ☐ Work Status ☐Radiology Disk ☐ Billing Statement ☐ Other: _____

Authorization to Release Protected Health Information

I understand that: I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (Please Initial)

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, if will not have any effect on any actions taken prior to receiving the revocation.
- ✓ **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will not expire.*
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

Signature*: _____ **Date:** _____

**For non-emancipated minors under the age of 19 years, a parent or guardian must sign release form. If patient is unable to sign a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*