Authorization to Disclose Protected Health Information

Pulmonary & Sleep Associates of Alabama

I, the undersigned, authorize
Pulmonary & Sleep Associates of Alabama
2022 Brookwood Medical Center, ACC Ste 310
Birmingham, AL 35209-6807
Ph. 205-871-9112 ● Fx. 205-871-9114
to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

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

Release Information To

Section must be filled out completely for request to be processed.

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Please forward the Records by: ☐ Mail ☐ Fax (For Doctor's Office Only!)

Information to be Released

☐ Please provide a **1 year** abstract of my records (includes most recent notes, labs, diagnostic testing)

☐ Please provide a **2 year** abstract of my records

☐ Please provide my **entire** record

☐ **Other** (please specify): _____
_____
_____
_____

I understand I will be responsible for the charges incurred in the release of my protected health information. The following fees will apply: *Copy fee: $1.00 per page for the first 25 pages*
$0.50 per page, thereafter.
(See AL Statute Section 12-21-6.1)
Records being sent to another healthcare provider will be provided at **no cost**.

*Please provide an **Email Address** to have invoice sent. If you do not have an email, an invoice will be mailed to address provided above.*

_____

Authorization to Release Protected

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (initials of Patient or Legal Representative)

I understand that:

1. I understand that authorizing the disclosure of this health information is voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing, but if I do, it 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 an expiration this authorization will expire in 90 days.
3. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I can request a copy of this form after I sign and date it.

STOP *Please confirm that you have filled out this form in its entirity--including the protected information categories above, regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

***Verified identity by: (Please check the applicable box below or provide further explanation)**
☐Driver's License ☐Military I.D. ☐ (Proof of Legal Guardian, Attorney of Record, Insurance) ☐Other: _____