917 Tuscaloosa Avenue, S.W.
Birmingham, AL 35211
Phone 205-780-7150
Fax 205-783-9326

Authorization to Release Medical Information

Patient Name: ____

Patient Date of Birth: ____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Description of the information to be used or disclosed including the Dates of Service related to such information ____

____

____

The above information will be called "Authorized Information" throughout the rest of this form. Persons or Class of Persons Authorized to make the use or disclosure of Authorized information:

____

Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made:

____

Authorized information will be used and/or disclosed at the request of the individual

I understand that if the person or entity receiving Authorized information is not a health plan or healthcare provider covered by federal privacy regulations, the authorized information maybe re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying The Surgeons' Group in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by The Surgeons' Group before receiving the revocation.

This authorization expires at the earlier of ________________or a year from the date the following event occurs:

Signature of Patient or Patient's Representative: ______________________________

Date: ______________________________