



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION



PATIENT INFORMATION

Patient's Name _____ Birth Date _____

Address _____

City, State, Zip _____

Social Security Number _____ Phone _____

RELEASE

Date of Request _____ Date Information Needed _____

THE UNDERSIGNED PATIENT HEREBY AUTHORIZES THE EMPLOYEES OF

Facility Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

TO RELEASE MY PROTECTED HEALTH INFORMATION IDENTIFIED BELOW TO EMPLOYEES OF THRIVE ALABAMA.

112 S. Pine Street | Suite 202
 Florence, AL 35630
 256-764-0492 | 256-764-1670 FAX

PURPOSE FOR THIS REQUEST

Transferring Care Personal—Not Transferring Care Work Related Insurance Coverage

Other _____

TYPE OF RECORDS REQUESTED (CHECK ONE)

Specific Information (select one, or more, as applicable)

<input type="checkbox"/> Consult	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Discharge & Summary
<input type="checkbox"/> Office Notes	<input type="checkbox"/> HIV Related Tests	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Other _____		

All Medical Records related to a specific illness or injury

Specific illness/injury _____ Date(s) of Treatment _____

All Medical Records

Specific description of records _____

- I understand that I may change my mind and revoke this Authorization at any time in writing, except to the extent the releasing party has already relied upon this Authorization.
- I understand that protected health information disclosed based on this Authorization may be redisclosed by the receiving person or entity and may no longer be protected from disclosure to others by federal or state law.
- I understand that protected health information disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that neither Thrive Alabama nor the releasing party may condition my treatment on my execution of this Authorization to Obtain Protected Health Information.
- I understand that this Authorization expires one year from the date of signature, or the following earlier date _____.
- I acknowledge that the party releasing my records will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

NOTE TO RELEASING ENTITY: Thrive Alabama and its individual employees, shareholders, officers and directors make no representations or warranties whatsoever with regard to this release, your use of this release, the adequacy of this release under any applicable law, or the sufficiency of this release to protect your interests. The releasing entity hereby assumes all risks arising from the use of this release.

Signature _____ Date _____