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)

❑ Consult ❑ Laboratory Results ❑ X-Ray Reports ❑ Discharge & Summary
❑ Office Notes ❑ HIV Related Tests ❑ History & Physical ❑ Operative Report
❑ Mental Health ❑ 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 __________

Please send this form to: patientaccess@thrivealabama.org