Alabaster Pediatrics, LLC
Patient Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address: _____

City, State, Zip: _____ Phone: _____

Entity or person who will release the information:

Doctor Office/Name: _____

Address: _____

City: _____ State: _____ Phone: _____ Fax: _____

- ☐ Entire record
- ☐ Office visit notes
- ☐ Diagnostic studies (list): _____
- ☐ Other as listed: _____

Entity or person who will receive the information:

Doctor Office/Name: ALABASTER PEDIATRICS

Address: 1004 1ST STREET NORTH, SUITE 370 ALABASTER AL 35007

Phone: 205-663-5547 Fax: 205-663-1990

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised June 2016