**Bama Pediatrics** **Phone (205) 333-5900**
**920 Rose Drive** **Fax (205) 333-6090**
**Northport, AL 35476** **Direct message: bama.peds@al1050.direct.successehs.com**

_____ _____
Patient's name Date of birth

I authorize _____ to use or release/disclose my health information as described below.
Please identify the information to be released:

- ☐ Please release my entire records
  -OR-
- ☐ Please release only the following information
  - ☐ Immunization records ☐ X-ray and imaging reports ☐ Lab results
  - ☐ List of allergies ☐ Consultation reports ☐ Other _____

The identified information will be used for the following purposed:

- ☐ My personal records
- ☐ Transferring to another doctor
- ☐ Other (please describe):_____

Please initial each item below to indicate your understanding:

_____I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is release, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure heath care treatment.

**Reason for leaving the practice**:_____.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Phone: _____
Address: _____ Fax: _____
_____

This authorization will expire on _____.
If I fail to specify an expiration date or event, this authorization will expire in twelve (12) months from the date on which it was signed.

_____ _____
Print name of person signing release Relationship to patient

_____ Date: _____
Signature (or signature of person completing for if not patient)

_____ _____
Signature of Witness Date