AUBURN PEDIATRIC AND ADULT MEDICINE

AUTHORIZATION FOR MEDICAL RECORD RELEASE

Patient Information

Full Name:_____

Address:_____

DOB:_____ SSN:_____ Phone:_____

Physician's Name:_____

Address:_____

Phone:_____ Fax:_____

send here ☐

☐ send here

⇦⇦⇦⇦⇦⇦⇦ **CHECK ONE OF THESE BOXES** ⇨⇨⇨⇨⇨⇨⇨

Auburn Pediatric and Adult Medicine, L.L.C.
2353 Bent Creek Rd, Suite 110, Auburn, AL 36830. 334-887-8707

Fax: (334) 887-8706 ***Please Fax if Possible***

Please Send:

☐ Encounter notes ☐ Lab reports ☐ Pathology reports
☐ Immunizations ☐ Growth curves ☐ Radiology reports
☐ Medication summary ☐ Other:_____

The purpose of this medical record release is: ☐ Continued care ☐ Insurance issue ☐ Attorney use ☐ Social Security ☐ Veterans affairs ☐ Other:_____.

I understand that these records may contain information about cancer diagnoses, drug/alcohol abuse, psychiatric diagnoses, HIV/AIDS status, other sexually transmitted diseases, and financial or payment history. **I understand that** I may request a copy of this form. **I understand that** my signature below is voluntary and not a requirement for medical care to be provided. **I understand that** I can revoke this authorization at any time by written request (to Office Manager, Auburn Pediatric and Adult Medicine, 2353 Bent Creek Rd, Suite 110, Auburn, AL, 36830), but that such revocation will have no affect on any action taken prior to receiving this revocation. **I understand that** my authorization will expire in 1 year, or on the following date __/__/__. **I understand that** my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law (i.e. we can't guarantee what they do with it).

I authorize the release of medical records, and for this form to be sent to the medical provider listed above by mail, fax or other form of communication. Auburn Pediatric and Adult Medicine, its agents and employees are hereby authorized to obtain, inspect, reproduce, or release such records and/or information and are hereby relieved of any responsibility or liability that may arise from this release or reproduction in accordance with this authorization.

_____	_____	_____
Patient/Guardian Signature	Date	Witness Signature
_____	_____	_____
Printed Name	(Relation to patient)	Printed Name of Witness