Fairhope Family Medicine, LLC
21875 Hwy 181
Fairhope, AL, 36532
251-928-1442

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing, I _____ authorize Fairhope Family
Patient/Dependent Name
Medicine, LLC, to use and/or disclose certain protected health information (PHI) about me/my dependent to the following individual(s); as well I acknowledge that I have received or been offered a copy of Fairhope Family Medicine's Notice of Privacy Practices:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

This authorization includes but is not limited to disclosure of information by phone, mail or other means of communication unless otherwise stated.

_____	_____
Signature of Patient/Legal Guardian	Date