Fairhope Family Medicine, LLC
21765 Highway 181
Fairhope, AL 36532
Phone: 251.928.1442 Fax: 251.210.0969

Authorization for Release of Medical Record Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Telephone No.:_____

I hereby authorize:

Fairhope Family Medicine
21765 Highway 181
Fairhope, AL 36532

Phone 251-928-1442
Fax 251-210-0969

to disclose information from my / my minor child's medical records to:

Name: _____ Address:_____
City: _____ State: _____ Zip: _____

Contact Email: _____

I authorize the above entity/person to disclose the information requested as indicated below. I understand that portions of my record may have extra protection under Alabama or federal law, including information relating to mental health, alcohol or substance abuse, developmental disabilities and HIV status or test results. However, if any such information is included in the information held by the entity/person identified above, I hereby authorize the disclosure of that information. I authorize electronic media for records transfer.

The records custodian will release all records. There is no means by which to send only specific information.

This information is needed for the following reason:

__ Transfer of Care – Fairhope Family Medicine has closed

__ Other (specify) _____

I understand that I may revoke this consent, in writing, at any time, except where information has already been released. I am aware that the withdrawal is not effective until received by Fairhope Family Medicine.

_____ _____
Signature: (Parent or Legal Guardian if Minor Child) Date:

This authorization is valid for a ninety (90) day period from the date it is signed.

Witness: _____