**Fairhope Family Medicine, LLC**
**21875 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: _____ Medical Record No.: _____
City: _____ State: _____ Zip: _____
Telephone No.:_____

I hereby authorize:
Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Ph: _____ Fax: _____

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

Fairhope Family Medicine
21875 Highway 181
Fairhope, AL 36532

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

I authorize the above entity/person to disclose the information requested by Fairhope Family Medicine, LLC representatives 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.

The specific information I wish to have released is:

__ Discharge Summary __ History & Physical __ Progress Notes __ Operative Notes __ Pathology Reports
__ Lab Reports __ Radiology Reports __ EKG/ECHO/Cardiac Cath __ Emergency Reports
__ All Records __ Other _____

(include dates of treatment)_____

NO ELECTRONIC MEDIA PLEASE (i.e disks or usb drive).
THIS REQUEST IS SENT AS A COURTESY TO OUR PATIENT AT THE PATIENT'S REQUEST AND ANY COSTS DUE FOR COPIES MUST BE BILLED TO THE PATIENT AND NOT FAIRHOPE FAMILY MEDICINE

This information is needed for the following reason:

__ Transfer of Care __ Continuation of Care __ Payment of Claim(s) __ Coordination of Benefits

__ 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: _____