Alabama Orthopaedic Clinic, P.C.

3610 Springhill Memorial Drive North
Mobile, Alabama 36608
(251) 410-3652 Telephone
Fax (251) 410-3641 Email Address: roi@alortho.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

Phone #_____Work or Wireless #_____

Patient Social Security #:_____Doctor:_____

Reason for request: _____

Date(s) of service needed: From _____To_____

Authority to Sign for Patient (attach documents) Parent of Minor Child
Power of Attorney
Representative of Deceased Estate
Representative of Incapacitated Adult

I authorize Alabama Orthopaedic Clinic: to release my medical records to:

_____

_____

_____

Options: Pick up Mail Electronic- Web Delivery - Email Address_____

Medical Records Fee

☐ **Abstract Copy $20** ☐ **Disk of Images $8**

☐ **Complete Chart Amount Due $_____ # of pages provided _____**
$1.00 a page 1-25 & $.50 a page thereafter

Processing time 7 to 10 business days

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Patient Signature:_____Date Signed:_____

* Expiration date is one year from date signed unless otherwise stated:_____
* A photocopy or fax of this authorization is as valid as the original.

FOR OFFICE USE ONLY - AOC Employee: _____

Amount Paid $_____ ☐Cash ☐Check ☐Credit Card ☐Debit

Collected By:_____