

Alabama Orthopaedic Clinic, P.C.

3610 Springhill Memorial Drive North
Mobile, Alabama 36608
(251) 410-3600 Telephone
Fax to (251) 410-3641 or Mail to the above address

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Preparation time – 7 to 10 Business Days

Call when ready

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:

Medical Record Copying Charges

A copy service is used to copy our records. The following charges apply to copying records requested for personal use, attorneys, insurance purposes, disability determination and various other reasons:

\$5.00 Base Fee
\$1.00 per page for pages 1-25
\$.50 per page thereafter
Actual postage (if applicable)

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 - 🍏 FILE ONCE SIGNED - CHART
