PARTNERS IN HEALTH
FAMILY MEDICINE

)7216 Copperfield Dr.
Montgomery, AL 36117
O)334.244.1359
F)334.

Patient Name:	Phone:	Date of Birth:

Request Information From:

Provider Name:		Telephone:
Address:		Fax:
City:	State:	Zip:

*This authorization may be revoked at any time upon your request. If you would like the above-named care provider to have access to your records or you are requesting access to your records, please choose one of the following:

Purpose for the disclosure: _____
Please check if specific information is to be released/requested:

_____Last 2 years of office visit notes _____Lab results (last 2 years)

_____Other: _____

Note: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Provider to release any of the following by initialing all that apply.

_____ Genetic information
_____ Substance/Alcohol abuse
_____ HIV/AIDS
_____ Mental/Behavioral Health

Permission is hereby granted to Partners in Health, PLLC to obtain/release medical information from/to the provider identified above. This request will expire within one year from date of signature.

Patient/Authorized Signature:	Print Name:	Date: