CEDAR STREET MEDICAL ASSOCIATES, LLC

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Hartselle, AL 35640
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RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

Note to Recipient of Records: The patient's medical record is privileged information which is protected by various State and Federal laws. Information may not be further disclosed to other persons without a separate authorization from the patient.

PATIENT INFORMATION:

Name: _____

Address: _____

_____

_____

DOB: _____

Phone #: _____

RELEASE TO:

Name: _____

Address: _____

_____

_____

Phone _____

_____

RELEASE FROM:

Name: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

I, _____ authorize _____ to release to the party listed the following information from my medical records: (Circle the appropriate items)

Complete Record	X-Ray/Imaging Reports
History & Physical	Surgical/Procedure Reports
Medication Record	Laboratory Reports
Recommendations/Physician Orders	X-Rays
Other _____	

I request and authorize the above-named health care provider to release the information specified above to the organization(s) or individual(s) listed on request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia testing: Human Immunodeficiency Virus (HIV); Drug Abuse; Alcoholism; Alcohol Abuse, If any; Acquired Immune Deficiency Syndrome (AIDS); Psychological or psychiatric conditions, if any.

I understand that:

1. My signature on this form is strictly voluntary.
2. I may revoke this authorization any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving this authorization.
3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and no longer be protected by federal privacy regulations.

_____
(Patient's Signature) (Date)

_____
(Patient's, Legal Guardian's or Agent's Signature) (Date)

I witnessed the signature on this form: (please print) _____

_____
(Witness's Signature) (Date)