Phone: 256.640.8416 *FAX: 256.640.8450*

Authorization for Release of Medical Information

Patient Information

Full Name: _____

Date of Birth: _____ Phone Number: _____

I hereby authorize:

Marshall Primary Care

To release medical records to / obtain medical records from: (circle one)

Name of Provider or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorization and Understanding:

- I understand that this authorization is voluntary.
- I understand that I may revoke this authorization at any time in writing.
- I understand that the revocation will not apply to information already released in response to this authorization.
- I understand that authorizing the disclosure of this health information is voluntary and I do not need to sign this form to receive treatment.
- I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy regulations.

This authorization will expire on: _____ (If no date is provided, authorization will expire in 12 months from the date of signature.)

Signature of Patient or Legal Representative:

Signature: _____Date: _____

Printed Name:

____________________________________Relationship__________________