FLINT RIVER FAMILY MEDICINE, P.C.

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Phone: 256-469-6487
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AUTHORIZATION TO OBTAIN / RELEASE MEDICAL RECORDS

Physician to provide records: _____

Patient's Name: _____

SS#: _____ DOB: _____

Person/Facility to receive records: _____

Address: _____

City: _____ State: _____ Zip: _____

Release these records: Initials

1. Only records generated by this facility(not including records received from other sources)…____
2. Only some portion of records maintained at facility(date of treatment, etc. specify below)…____
3. All medical records at this facility……____

_____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials

_____ Substance abuse, if any

_____Psychological or psychiatric condition, if any

Initials

_____ HIV/AIDS results, if any

Other (please specify)_____

Expiration of revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient's Name:

_____
(Print name)

_____
Patient Signature Date

Person Authorized to sign for patient:

_____
Print name

_____
Authorized Person Signature Date

I understand that this Authorization expires one year from the date of signature,

or the following earlier date_____.