RELEASE OF INFORMATION AUTHORIZATION/REQUISITION FORM

Section A: *This section to be completed by the patient.*

Patient Name:		Medical Record #:	
Address:		Social Security #:	
		Date of Birth:	

RELEASING Facility	
Facility Name:	Northwest Medical Center
Address:	1530 U.S. Highway 43
City/State/Zip:	Winfield, AL 35594
Phone #:	205.487.7724 fax: 205.487.7968

REQUESTING Facility or Individual	
Requestor Name :	
Address:	
City/State/Zip:	
Phone:	

Date(s) of Service:	
Purpose of Disclosure:	

List specific description of information to be released:

- ❑ Anesthesia
- ❑ Billing Records
- ❑ UB92
- ❑ Itemized Bills
- ❑ Consult
- ❑ Discharge Summary
- ❑ EKG's
- ❑ Emergency Records
- ❑ Face Sheet
- ❑ History & Physical
- ❑ Imaging Reports
- ❑ Laboratory
- ❑ Medication Records
- ❑ Nursing Records
- ❑ Operation/ Procedure Report
- ❑ Physician Orders
- ❑ Outpatient Records
- ❑ Pathology Report
- ❑ Progress Notes
- ❑ Accounting of Disclosures
- ❑ All Records
- ❑ Other ________
- ❑ ________
- ❑ ________
- ❑ ________
- ❑

Section B: *Must be completed by the patient for all authorizations:*

The patient or the patient's representative must read/acknowledge the following statements:

I understand that the persons hereby authorized to use/disclose Information will not condition treatment or payment on my providing this authorization.

I understand that this authorization will expire one year from the date signed.

I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.

I understand that I may see the information described on this form if I ask to see it, and I understand that I may will receive a copy of this form after I sign it, if requested.

I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.

I understand that I may refuse to sign this authorization and, in doing so, understand refusal to sign this authorization will not affect my treatment.

I hereby authorize the use or disclosure of my individually identifiable protected health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, and/or mental disorders. In accordance with Federal regulation 42 CFR part 2: I also understand that release of any and all alcohol and/or drug abuse treatment records cannot be released without my specific authorization, except in special circumstances. Therapists notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

(Signature of Patient or Patient's Representative) (Date)

(If patient representative, please print name above)

(Basis for which representative has the authority to act for the patient)

FOR OFFICE USE ONLY:	
Verified :	Yes No
By:	
License #	
SS #	
Signature:	Yes No