## Authorization to Receive or Disclose Health Information

PERRY
Medical Clinic

**401 Northwood drive**
**Centre, AL 35960**

**Phone number: 256-927-3607**
**Fax number: 256-927-3605**

**Dr. Clinton Allen** **Dr. William B. Perry** **Dr. Sheri Frickey**
**Joy Allen, CRNP** **Haley Trammell, CRNP** **Lauren Coursey, CRNP**

Patient Name: _____DOB:_____

1. I authorize Perry Medical Clinic, PC to request, use, or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (included dates where appropriate) _____

_____

_____

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ☐ **Requested From** ☐ **Disclosed To and Used by** the following individual or organization:
Name:_____
Address:_____
For the purpose of:_____

**At the request of the individuals:**

Phone number:_____Fax number:_____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy/Security officer. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclousre and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Joy Allen, Privacy Officer.

I understand that I may be charged for Medical Records. Standard charges for electronic records will be based on actual expense to reproduce the records. Paper records will be charged in accordance with the standard medical record fees as dictated by the state medical board, not to exceed $1.00 per page for the 1st 25 pages; then $0.50 per page for all subsequent pages. There is no charge for records to be sent to another provider we refer to.

_____ _____
Signature of Patient or Legal Representative/Relationship Date

_____ _____
Signature of witness Staff Member Processing Request