FAULKNER UNIVERSITY
CENTER FOR THERAPY AND RESEARCH

MEDICAL RECORD INFORMATION **AUTHORIZATION for the RELEASE of MEDICAL INFORMATION**

INSTRUCTIONS: This from is to be used by a patient or legal representative to authorize the release of information to a third party. Print clearly, each section needs to be completed to be valid.

1. **PATIENT INFORMATION:**

Patient Name: _____ Phone Number: _____ Date of Birth: _____

2. **RELEASE PURPOSE**

Check the appropriate box or write in other purpose.

___ Continuing Care ___ Disability ___ Forms completion ___ Insurance ___ Legal

___ Worker' compensation ___ Other, specify _____

RELEASE INFORMATION TO:

Faulkner University Center for Research and Therapy
5445 Atlanta Highway
Montgomery, AL 36109
Office: 334-383-7351
Fax: 334-386-7354

3. **INFORMATION TO BE RELEASED:** Review options and check appropriate box(es):

DATES OF SERVICE TO BE RELEASED: From _____ to _____.

Document/Note(s) (check all that apply)

___ Behavioral health/Mental/Psychological notes ___ Emergency Department/Urgent care notes
___Operative/Procedure notes ___Provider notes
___ History & Physical notes ___Discharge reports
___Therapy notes (physical, occupational, speech) ___Other, specify _____

I understand the information to be released may include behavior and/or mental health care.

Additional Records (check all that apply)

___ Allergy list ___ Laboratory results ___Pathology report(s)
___ Immunization ___ EKG(s)/Cardio/Echo ___ Treatment plans
___ Medication list ___ Assessment/Evaluation

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___ Treatment/Discharge Summary ___ Radiology image(s), specify exam(s)/body part(s)
___ Other, specify _____.

4. **AUTHORIZATION:** Permission is hereby granted to:

Name: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

5. **Signature and Date:** The Patient or legal representative must sign and date this authorization.

I understand that I do not have to sign this authorization in order to receive treatment from **Faulkner University**. I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer: Jan Welch, Clinic Manager, Faulkner University, Clinical Center, 5445 Atlanta Highway, Montgomery, AL, 36109.

Patient/Authorized Signature: **Print Name:** **Date:**

_____ _____ _____

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

___ Parent ___ Stepparent ___ Legal guardian ___Foster parent
___ Healthcare power of attorney/agent ___ Other _____