MEDICAL ASSOCIATES OF THE SHOALS, P.C.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:	**DATE OF BIRTH:**
ADDRESS:	**SOCIAL SECURITY NUMBER:**

I hereby authorize Medical Associates of the Shoals, P.C. to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

Use the following health information maintained by Medical Associates until:

_____

Expiration Date/ will expire one year from signed date unless otherwise specified above.

☐ **DISCLOSE the following health information to**:

To:_____

Address:_____

City::_____

State:_____**Zip:**_____

Phone:_____

Fax:_____

☐ **OBTAIN the following health information from:**

To:_____

Address:_____

City::_____

State:_____**Zip:**_____

Phone:_____

Fax:_____

Specific description of the health information to be used/disclosed/obtained (*include dates and type of service).*

_____

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*):

_____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.
2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
3. I understand that Medical Associates will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.
5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
6. I understand that I may revoke this Authorization at any time by notifying Medical Associates in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
7. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.
8. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
9. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient's Representative (*if applicable*) | Representative's Relationship to Patient (*if applicable*)

Revised: 7/25/2019