AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CUSTOM FAMILY CARE
279 Hughes Road, Madison, AL 35758
tel (256) 325-0480 fax (256) 325-0481

Medical Record Number_____

Patient Last Name:_____ First Name_____ MI_____

INFORMATION REQUESTED FROM:	REQUESTOR OF INFORMATION ( ) self ( )other:
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone #:_____	Phone #:_____

INFORMATION TO BE DISCLOSED:
( ) Progress Notes ( ) Labs ( ) Procedure ( ) Entire Record

ACKNOWLEDGEMENT OF UNDERSTANDING:
- This authorization will remain in effect for 30 days.
- I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by Federal privacy regulations.
- There will be no conditions placed on my health care or payment for my health care.
- I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

Patient/Guardian/Representative Signature:_____ Date:_____

Patient/Guardian/Representative Printed Name:_____

Witness Signature:_____ Date:_____