Southeast Surgical Associates | Southeast Alabama Medical Center (SAMC)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM OTHER FACILITIES

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

_____

Social Security #: _____ Telephone: _____

Information To Be Released From:

Name of Facility: _____

Address: _____

Information To Be Released -- Covering the Periods of Health Care

_____

_____

From (date) _____ to (date) _____

Where to Send Information

Name: Southeast Surgical Associates	Phone: 334-792-5184
Address: 1812 E. Main Street	Fax: 334-792-5190
Dothan, AL 36301	

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Circle One: **Yes** **No**

I understand if my medical or billing records or psychotherapy notes contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
Circle One: **Yes** **No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Medical Records Manager at Southeast Alabama Medical Center, P. O. Box 6987, Dothan, AL 36302. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. SOUTHEAST ALABAMA MEDICAL CENTER, ITS AFFILIATES, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I authorize SOUTHEAST ALABAMA MEDICAL CENTER to use and disclose the protected health information specified above.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship if not patient: (Guardian/Executor of Estate/Personal Representative) Day time phone number

Witness: _____