

Birmingham Gastroenterology Associates
Authorization to Disclose Protected Health Information
205-271-8000 • 205-879-7061 Fax

Patient Name: _____ Date of Birth: _____

Medical Record Number or SSN: _____

The following person or entity is authorized to disclose my medical records:

From: _____

Please route records to:

- W. Roger Carlisle, MD
- Leonard Ou-tim, MD
- J. Lynn Cochran, MD
- Raymond Tobias, MD
- P. David Miller, MD
- Mark R. Janich, MD
- H. Craig Philpot, MD
- J. Cotton Shallcross, MD
- Kenneth M. Sigman, MD
- Charles S. Bluhm, MD
- Owen R. McLean, MD
- David J. Landy, MD
- Chistopher P. Shaver, MD
- Douglas S. Dickinson, MD
- Kay Parker-Phillips, CRNP

The disclosure will be made to the following person or entity:

To: **Birmingham Gastroenterology Associates**
1 Independence Plaza, Suite 900
Birmingham, AL 35209
(205) 271-8000 Fax (205) 879-7061

For the purpose of:

At the request of the patient,

OR: _____

The type and amount of information to be used or disclosed:

- Problem list
- Medication list
- List of Allergies
- Immunization Record
- Most Recent History and Physical
- Most Recent Discharge Summary
- Psychotherapy Records From (date)_____ to (date)_____
- Laboratory Results From (date)_____ to (date)_____
- X-Ray and Imaging Reports From (date)_____ to (date)_____
- Consultation Reports From (Doctor's Name(s)) _____
- Entire Records

Other _____

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it 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. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this authorization.

Signature of Patient or Personal Representative

Date

Relationship of Personal Representative to the Patient

Signature of Witness