Alabama Colon & Gastro, P.C.

Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient's Name: _____Date of Birth:_____

Social Security #: _____

Person/Facility to receive records: Alabama Colon & Gastro, P.C.

Address: 1105 Eagletree Lane SE
City, State, Zip: Huntsville, Alabama 35801
Records Fax: 256.513.8141

Release these records: Inititals

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (dates of treatment, etc., specify below _____
3. All medical records at this facility _____
   _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the EXCEPTION OF:

Initials

_____ Substance abuse, if any

_____ Psychological or psychiatric conditions, if any

Initials

_____ AID/HIV, if any

Other (Please specify) _____

_____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name (print):

_____

Patient Signature:

_____

Date: _____/_____/_____

Person authorized to sign for patient:

_____

Signature:

_____

Date: _____/_____/_____

Alabama Colon & Gastro, P.C.
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Huntsville, Alabama 35801
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