Authorization for Release of Medical Records to Grace Internal Medicine

Facility/Provider to Release Medical Records: _____

Address: _____

City/ State/ Zip Code: _____

Phone Number: _____

Fax Number: _____

I hereby authorize the above named Facility/Provider to release medical records in its possession, including information regarding my medical condition and treatments to:

Grace Internal Medicine
Dr. Vanosia S. Faison
102 Medical Center Drive
Suite F
Prattville, AL 36066
Phone: (334) 568-2335
Fax: (334) 568-2336

I understand that my signature below specifically authorizes the release of health care information relating to diagnosis or treatment for: HIV/AIDS virus, Mental Health/Psychiatric Disorders, Sexually Transmitted Disease(s), Drug/Alcohol Abuse/Treatment, if they are a part of my medical records. I understand that this authorization is voluntary.

____ Release medical records for date(s) of service.

____ Release entire medical record.

____Release these specific documents: Other :_____

- History and Physical
- Discharge Summary
- Pathology Report
- Diagnostic Procedures
- Emergency Room Record

Expiration Date of Authorization: The authorization will automatically expire one (1) year from the date of signature. We will not honor request for disclosure after expiration without an updated authorization form. You may renew or alter this authorization form at any time.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Grace Internal Medicine, LLC at the location listed above. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request.

Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization: If you refuse to sign this authorization, Grace Internal Medicine will not deny you treatment.

This form authorizes Grace Internal Medicine, LLC to use and/or disclose protected health information (PHI) in the manner described above and is voluntary. Grace Internal Medicine, LLC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used and/or disclosed as a result of the Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

_____ _______________ _____

Print Patient Name Date of Birth Last four digits of SS#

_____ _______________

Signature of Patient Date of Authorization

NOTE: Authorization is not valid without a signature and a date by the patient. The request must be filled out completely.