AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

To:

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Please Release Information To:

Preferred Medical Group: **Centralized Fax: (334) 664-0466**

Preferred Medical Group Location**:**

- ☐ Phenix City | 3700A S. Railroad St. Phenix City, AL 36867 | 334) 664-0463
- ☐ Opelika Hwy 280 l 5809 Highway 280 East Opelika, AL 36804 | (334) 275-3059
- ☐ Fort Mitchell | 2 Gilmore Road Fort Mitchell, AL 36856 | (334) 664-1960
- ☐ Opelika Executive Park | 2112 Executive Park Drive Opelika, AL 36801 l (334) 749-2007

Information Requested:

- ☐ Immunization Record/Growth Chart / Last well Visit
- ☐ Labs/X-Rays
- ☐ Complete Medical Records
- ☐ Medical Summary

Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Continuing Care
- ☐ Other (Please Specify) _____

Informed Consent for Release of Confidential Information.

I understand that I may revoke this consent in writing at any time except to the extent action has been taken.
I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations.

_____ _____
Signature of Patient or Legal Representative Date

Relationship to Patient _____