



Patient's Name: _____

Social Security #: _____ - _____ - _____ **Date of Birth:** _____ - _____ - _____

Address: _____

Daytime Phone #: _____ **Alternate/Maiden name:** _____

I authorize Citizens Baptist Medical Center/BBH to release and/or disclose my protected health information (PHI) as described below:

Person / Organization receiving information:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Email Address: _____

Specific Information Requested:

Dates of treatment: from: _____ to: _____

____ History & Physical

____ Discharge Summary

____ Operative Report

____ Consult Note

____ Entire Record

____ Other, specify _____

____ Labs

____ Radiology Reports

____ Pathology Report

____ Progress notes

____ Emergency Room Report

By initialing next to a category listed below, I specifically authorize Citizens Baptist Medical to use and/or disclose my highly confidential information. **Initial each category that Citizens Baptist Medical/BBH is authorized to release.**

____ Mental Health / Psychiatric Records

____ Alcohol and/or Drug Abuse Records

____ Information about sexually transmitted diseases

____ HIV/AIDS related testing (whether the results were positive or negative)

____ Information about sexual assault

____ Information about child abuse / neglect

____ Psychotherapy notes

The purpose for the use/disclosure of the information is:

____ Personal use

____ Physician care

Other, specify: _____

____ Legal

____ Insurance

Authorization to Use and Disclose Protected Health Information

Unless otherwise revoked, this Authorization will expire: _____.

(Date or Event)

If I fail to specify an expiration date or event, this authorization will expire six months from the date it was signed.

I understand that once BBH discloses my PHI to the recipient, BBH cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.

I understand that according to state and federal law I may be charged a reasonable fee by the releasing facility for the photocopying of the requested records. I understand that BBH may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my PHI.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at BBH; except, however if my treatment at BBH is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case BBH may refuse to treat me if I do not sign this Authorization.

I understand that if I revoke this Authorization, I must send written notice of revocation to BBH's Custodian of Records at the address listed below. The revocation will be effective immediately upon BBH's receipt of my written notice. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I may contact the Custodian of Records at the address listed below or by email at HIMPrivacyOffice@bhsala.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly and voluntarily authorize BBH to use or disclose my PHI in the manner described above.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness

Date

- Please fill out the authorization completely. If sections are blank or incomplete, we may not be able to process your request.
- When submitting your request for medical records, please enclose a copy of your Photo ID.
- If the records are for a patient whom you have Power of Attorney, please enclose a copy of the POA.
- If the records are for a deceased patient, please provide a copy of the Executor of Estate and Death Certificate.

Completed Authorizations and any required paperwork can be mailed to:

Citizens Baptist Medical Center

ATTN: HIM/Release of Information

604 Stone Ave

Talladega, AL 35160

Phone: 256-761-4523

Fax: 256-761-4569

Authorization to Use and Disclose Protected Health Information