

Southern Specialty Physicians



Patient Authorization to Release Medical Information

Patient Information

Full Name _____

Date of Birth: ____ / ____ / ____

Address: _____

Phone Number: _____

Release Information

I hereby authorize:

To release my medical records to:

Name of Facility/Provider: _____

Name of Person/Facility: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Purpose of Disclosure (check one):

☐ Continuing Medical Care

☐ Personal Use

☐ Legal Purposes

☐ Other: _____

☐ Insurance

Information to be Released (check all that apply):

☐ All Medical Records

☐ Operative Reports

☐ Lab Results

☐ Office Exam Notes

☐ Imaging/X-ray Reports

☐ Billing Records

☐ Other: _____

Dates of Service to Release:

☐ All

☐ From ____ / ____ / ____ to ____ / ____ / ____

Records Delivery (select one):

☐ Paper:

☐ Electronic:

____ Mailed to address on this authorization

____ Faxed to number: _____

____ Pick up by _____

____ Email to address: _____

Authorization and Signature

I hereby authorize the use of disclosure of my protected health information as described above. I understand that this authorization is voluntary and that I may revoke it at any time as outlined below.

- Rights to Revoke: You may revoke this authorization in writing at any time, except to the extent that the action has already been taken based on it. Instructions for revocation are available in our Notice of Privacy Practices.
- Conditioning of Services: Your treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization, unless permitted by law and specifically stated.
- Redisclosure Risk: Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Signature of Patient or Legal Representative: _____

Date: ____ / ____ / ____

Expiration Date ____ / ____ / ____

If signed by a Legal Representative, relationship to patient: _____

Witness (if required): _____

Date: ____ / ____ / ____