MR#: ☐☐☐☐☐☐ EP: ☐☐ Date: ☐☐ – ☐☐ – ☐☐☐☐
M M D D Y Y Y Y

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

5750-A Southland Drive; Mobile, Alabama. 36693
Health Information Management (HIM) Department – Phone: (251)450-4352; Fax: (251)450-1396

Please allow up to fifteen (15) days for processing.
Failure to complete EACH section will render this authorization invalid, and therefore it will not be processed.

Name _____ **Date of Birth** _____ /_____/_____
Address _____ **Social Security # (last 4 digits)** _____
City, State, Zip Code _____ **Phone Number** _____

I hereby authorize: AltaPointe Health and/ or Accordia Health

To □ obtain from OR □ release to: _____
Name

_____
Address and Fax Number

This consent and authorization may include, but is not limited to, release of medical, psychological, psychiatric, alcohol, drug abuse, STD, and HIV/AIDS information.

Purpose of Disclosure: □Personal □Attorney □Insurance □Disability/SSI □Continued Care □Other _____

The specific information to be released is:

□ Biopsychosocial
□ Medication Records
□ Progress Notes _____
□ Diagnosis
□ Other: _____
□ Psychological Testing
□ Treatment Plan
□ Laboratory Reports
□ Physician Orders
□ Psychiatric Evaluation
□ History/Physical
□ Discharge Summary
□ Entire Record

Date(s) of Service Requested: _____

Delivery Format: □ Paper □ CD/DVD □ Electronic Transfer (Portal) □ Certification (If needed)

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing. This authorization will expire (i) one year, (ii) after the disclosure is made, or (iii) the date specified here: _____, to accomplish the purpose of the disclosure stated above. I understand that I will receive a copy of this Authorization form after I sign it.

_____/ _____ _____
Patient Signature (14 and Older must sign with Guardian) Printed Name Date

_____/ _____/ _____ _____
Guardian/ Legal Representative Signature Printed Name Relationship Date

_____/ _____ _____
Witness Signature Printed Name Date

_____/ _____ _____
Second Witness Signature Printed Name Date

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under Title 45, CFR. AltaPointe Health may not condition treatment or payment on whether you sign this authorization, unless this authorization is for the provision of research-related treatment or for the creation of health information for disclosure to a third party.

Health Information Department:
Date Released: _____ HIM Staff Initials: _____/_____ Final Delivery Method _____