Montgomery Primary Medicine Associates
2055 East South Boulevard, Suite 308
Montgomery, Alabama 36116
Phone: (334) 286-2390 Fax: (334) 286-2397

Authorization to Release Information [Please Print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the **Montgomery Primary Medicine Associates** to release your protected health information to a person or organization that you choose.

Section A. Patient Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	Social Security Number:	Date of Birth:
Address: (including zip code)	**Telephone Number:** (including area code)	

Section B. Health Plan: (organization that will receive/release your information)

I authorize **Montgomery Primary Medicine Associates** to release my protected health information as described below.

Section C. Recipient: (person or organization that will receive/release your information)

Person's Name or Organization:	Telephone Number: (area code)
Address: (including zip code)	**Fax Number:** (if available)

Section D. Description of the Information to be Released: (what type of information will be released)

Check ONLY ONE box:

☐ **Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits or services.***

☐ **Specific information as described on the line below:***

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Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE**: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information ___________ (Initials) **HIV/AIDS** ___________ (Initials)

Substance/Alcohol Abuse ___________ (Initials) **Mental/Behavioral Health** ___________ (Initials)

Purpose of Release: ____

Examples: At my request; To resolve my appeal; To assist with my health insurance services

Section E. Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization*** ☐ **Upon the following date, event or condition*:**

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The party identified in Section B must be notified in writing of the event/condition to cancel or revoke this authorization.
Please note: State law requires that this Authorization to Release Information will automatically expire in 30 days for Alabama residents unless you specify a shorter timeframe.

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the release of my protected health information as described above.	**Personal Representative Information:** A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at our office.
______________________ (Print Name)	______________________ ______________________ (Printed Name of Personal Representative) (Description of Representative's Authority)
______________________ (Signature of Member)	__________ ______________________ (____)__________ (Date) (Signature of Personal Representative) (Telephone Number)
______________________ (Date)	