Brookwood Internists, P.C.
513 Brookwood Blvd., Ste. 50
Birmingham, AL 35209

Authorization for Use and Disclosure of Protected Health Information

I, _____, hereby authorize Brookwood Internists, P.C., its employees and/or agents to use and/or disclose the following protected health information to:_____
_____

(Specifically describe the information to be used or disclosed)

_____

_____

This protected health information is being used and/or disclosed for the following purpose(s): **(Provide a description of the purpose of each use and disclosure)**

_____

_____

1. ___ **At the request of the individual.**

2. **Complete if the Authorization is for marketing purposes**:
   The use or disclosure requested under this authorization ___ will ___ will not result in direct or indirect remuneration to Brookwood Internists, P.C. from a third party.
3. **Check one of the following statements below if request is from Brookwood Internists, P.C. :**
   ___ I understand that Brookwood Internists, P.C. may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure exception.

   ___ I understand that if I do not sign this Authorization, Brookwood Internists, P.C. may not provide services to me because protected health information is solely being created for use and/or disclosure to:
   _____

This Authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires. I understand that a reasonable fee may be charged to cover the cost of copying my records.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 513 Brookwood Blvd., Ste. 50, Birmingham, AL 35209. I understand that a revocation is not effective to the extent that Brookwood Internists, P.C. has taken action or reliance on the Authorization for use or disclosure of the protected health information prior to receipt of my revocation. I understand that upon my request I may see and copy the protected health information described on this Authorization. *I understand that my protected health information may include information concerning sexually transmitted diseases, behavioral and mental health services and treatment for drug and alcohol abuse, and I authorize the release of this information for the purposes stated above.* I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this Authorization. I release and discharge Brookwood Internists, P.C. from any and all liability, claims, and causes or action of any type arising out of the execution of this Authorization.

_____		_____	
Signature of Patient	Date	Printed Name of Patient	Date of Birth
_____		_____	
Signature of Personal Representative	Date	Authorizing Authority of Personal Representative	