CAHABA CONCIERGE MEDICINE

cahabaconcierge@gmail..com

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name: **Date of Birth:** **Email:**

Address: **Phone Number:** **Pharmacy:**

(FROM)Releasing Facility:
Facility Name:
Address:
City, State,Zip:
Phone:
Fax:

(TO)Receiving Facility:
Facility Name: Cahaba Concierge Medicine
Address: 8011 Liberty Parkway, Suite 101
City,State,Zip: Vestavia Hills, Alabama 35242
Phone: 205.255.4024
Fax: 833.921.2162

Health Information that may be used / disclosed is limited to the following:

✓ Entire Record ☐ Progress Notes ☐ Discharge ☐ Consultation ☐ Operative Note(s)
☐ ER Record ☐ Lab ☐ Imaging ☐ History & Physical ☐ Pathology Report ☐ Other (specify)

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to : medical records, x-ray films, slides, tracings, strips, etc. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information herein, to include alcohol, drug abuse, communicable disease including HIV status, and / or psychiatric diagnoses compiled during my visits, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

✓ Yes ☐ No

If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above. Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writings, as stated in the Notice of Privacy Practice, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patients or Authorized Personal Representatives Signature: **Date:**

Relationship to Patient/Authority to Act on Patient's Behalf :

Witness Signature: **Date:**
