ART FERTILITY PROGRAM OF ALABAMA
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MEDICAL RELEASE FORM

Date of Initial Appointment:_____

Patient Name: _____

Patient DOB: _____ Patient SS#: _____

Referring Physician: _____

Address: _____

I hereby authorize the physician listed above to disclose my health information to:

Honea, Houserman, Long & Allemand P.C.
Suite 508
2006 Brookwood Medical Center Drive
Birmingham, Alabama 35209
Fax: 205-870-0698

Please send the following information:

- Dates of service : From _____ to _____
- Specific Records: _____
- Entire OB/GYN and pertinent medical history records related to infertility care.

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying the referring physician listed above in writing, but if I do, it will not have any effect on uses or disclosure prior to the receipt of the revocation.
4. I understand that this Authorization will expire on _____/____/____(MM/DD/YR). Date must be entered!

_____ _____
Signature of Patient Date

After completing this release, please forward to your physician(s) for your medical records to be sent to our office prior to your appointment.