East Alabama Medical Center Medical Records
Patient Authorization Disclosure for Protected Health Information
PHOTO ID MUST ACCOMPANY REQUEST.

I. **Patient Name** _____**Social Security #** _____ **DOB** _____

Patient Address_____**City**_____**State**_____ **Zip** _____ **Phone** _____

II. I hereby authorize East Alabama Medical Center to disclose my health information to:

☐ **Name** _____

Address _____**City** _____ **ST** _____ **ZIP**_____

Fax number _____ (we only fax to physician offices and hospitals) **Telephone number** _____

☐ **Release the record to the patient indicated above.**

III. Specific description of the health information to be disclosed (include dates of service, type of service, etc.)

_____

This health information is disclosed for the following purpose (*if Authorization requested by the patient put "At the request of the individual"*): _____

IV. By providing this Authorization, I understand as follows:

A. I understand that this health information may include information regarding drugs and alcohol, human immunodeficiency virus test results, and psychotherapy notes.
B. 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.
C. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
D. I understand that I may revoke this Authorization at any time by notifying East Alabama Medical Center in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
E. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
F. I understand that this Authorization will expire on ____/____/_____ (MM/DD/YR) . If left blank, expiration date will be one year from date by signature.
G. I understand that my records will be provided to me in electronic format (CD) and that if I wish to have it in paper format I should initial here. _____ **(If left blank, it is understood that you wish to have your records in electronic format.)**

_____ _____
Patient or Patient's Representative's Signature Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient (if applicable)

V. **Production Costs**

A. If you are requesting that a copy of your records be sent directly to a physician's office involved in your medical care, EAMC will provide the records to the physician at no cost as a courtesy. These records will be sent to a verifiable fax/address for the physician listed.
B. If the record is released to any other entity, there is a charge for copying the medical record. Per the Office of Planning and Budget for the State of Alabama the fee schedule for this service is as follows:

Paper	**Radiology CDs/Films**	**Electronic Record**	**Postage**
$1.00 per page for pages 1-25	$8.00 per CD	Same as "per page" in paper format pricing	Actual postage costs
$0.50 per page for pages 26+	$8.00 per FILM		
$1.50 per page for all micro film copies			

East Alabama Medical Center utilizes Discovery Support Services to complete medical record requests. Any required payments for records will be made to and collected by Discovery Support Services. Radiology images should be picked up in the EAMC Medical Records Department. If you have any questions as to the bill or the status of your request, you may contact Discovery at: 334-528-2261, option 3. Requests will be mailed to the patient's home address, or may be picked up at the EAMC Medical Records Department.

I understand that I will be billed by Discovery Support Services for the charges incurred in processing my request and agree to pay any and all charges in full:

_____ _____
Patient or Patient's Representative's Signature Date

OFFICE USE ONLY: Time Now:_____ VIA:_____ Stay Type:_____ CD?_____ Time Completed: _____

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