

Alliance Medical Group, Inc.

Medical Records Release

Patient's Name _____ Date of Birth ____/____/____

I hereby authorize you to use or disclose the specific information described below only for the purposes and to the parties described below.

Description of the specific information to be used or disclosed for the following purpose(s):

Records Requested From: _____

Person or entity requesting the information and authorized to make the requested use or disclosure:

Records Sent To (Recipient of the Information): _____

I understand that:

- ❖ I may inspect or copy the protected health information to be used or disclosed.
- ❖ I may revoke the authorization in writing by contacting your office at the address above, attention Privacy Officer.
- ❖ Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- ❖ I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research related treatment, in which case you may refuse to provide that research related treatment).

If this box is checked, I understand that my full and complete medical records may include information regarding drug and alcohol use, mental health information and/or a history of acquired immune deficiency syndrome (AIDS) or related conditions.

If this box is checked, I understand that you will receive compensation from third party for the use or disclosure of my information.

Signature: _____ Date: ____/____/____

Relationship to Patient (if signed by personal representative of patient): _____

This authorization shall expire one year from date of signature.