IMPC
INTERNAL MEDICINE & PEDIATRICS OF CULLMAN, P.C.

1890 AL HWY 157, SUITE 430 • CULLMAN, AL 35058
PHONE: (256) 739-1575 • FAX: (256) 517-9328

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

❑ I authorize IMPC to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

OR

❑ I authorize IMPC Dr. _____ to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

Type Of Records Requested: (Check one)

Please mail records if over 25 pages

❑ Entire copy of the record checked above

❑ Immunization history

❑ Specific information (Select one or more, as applicable)

❑ Procedure report ❑ History & physical ❑ Physical Therapy ❑ Laboratory test results
❑ X-ray reports ❑ Other _____
(Please describe)

❑ HIV/AIDS/Sexually Transmitted Diseases: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

❑ Psychiatric/Mental Health Information Initial: _____ **Date:** _____

❑ Substance Abuse Initial: _____ **Date:** _____

This authorization will automatically expire one (1) year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- My information can be released by verbal communication, mail, fax, or email.

Signature of Patient _____ Date _____

Relationship to Patient (if requestor is not the patient) _____

Witness _____