SEALE HARRIS CLINIC
A Legacy of Quality Healthcare

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____
Patient SSN: _____
Patient's Phone #: _____

Medical Record #: _____
Patient DOB: _____
Patient's Address: _____
City, Stat, Zip: _____

Persons/ Organizations providing medical records:

Name: _____
Address: _____
City, Stat, Zip: _____
Phone #: _____

Person/ Organizations receiving medical records:

Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____

Specific Description of Information:

___ Face Sheet (From _____ to _____)
___ History and Physical (From _____ to _____)
___ Emergency Room Record (From _____ to _____)
___ Lab Reports (From _____ to _____)
___ Medication List (From _____ to _____)
___ Clinic Notes (From _____ to _____)
___ Consultation Reports (From _____ to _____)
___ Radiology Films (From _____ to _____)
___ Other (Please describe & Include dates of Service): _____
_____
_____

___ Discharge Summary (From _____ to _____)
___ Pathology Report (From _____ to _____)
___ Diagnostic Procedure Report(s) (From _____ to _____)
___ Problem List (From _____ to _____)
___ X-ray report(s) (From _____ to _____)
___ Operative report(s) (From _____ to _____)
___ Billing Records (From _____ to _____)
___ All Medical Records

Purpose of Use or Disclosure: This information for which I'm Authorizing disclosure will be used for the following purpose:

___ My personal Records
___ Sharing with other health care providers as needed
___ Other: (Please Describe): _____

805 St. Vincent's Drive * Suite 510 * Birmingham, Alabama 35205 * Phone: 205-595-5504 * Fax: 205-592-3427

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The patient or the patient's representative must read and initial the following statements: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand that I may revoke this Authorization at any time by notifying Seale Harris Clinic's Privacy Officer in writing, but if I do, it will not have any affect to the extent Seale Harris Clinic took action in reliance on the Authorization.

_____ I understand that Seale Harris Clinic may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under The following circumstances:

- Participating in research projects can be conditioned on my signing an Authorization to use and discloses PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

This authorization will expire: _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

Signature of patient or patient's representative:_____

Printed Name of Patient: _____

Printed Name of Patient's Representative: _____

Relationship to the Patient: _____

Date: _____

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