AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name: _____ Date: _____

Date of Birth: _____ SSN: _____

1. The following individual or organization is authorized to make the disclosure **(<u>if you are unsure of medical insurance/financial institution's EXACT legal name, leave blank and we will complete this for you</u>):**

   _____

2. The type and amount of information to be used or disclosed as follows:

   The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies **(<u>if unsure of EXACT dates per the complaint or demand, leave blank and we will complete this section for you</u>).**

   Dates of Services: From: _____ To: _____

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:

   GENTLE, TURNER, SEXTON & HARBISON, LLC
   501 Riverchase Parkway East, Suite 100
   Hoover, Alabama 35244
   (p) 205-716-3000 (f) 205-716-2364

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. Unless otherwise revoked, this authorization will expire upon the settlement of my claim.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits upon my giving this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM director, privacy officer, or other release of information employee of the above named healthcare provider.

_____ _____

Patient or Legal Representative

Relationship to Patient (If signed by Legal Representative)