SHELBY MEDICAL ASSOCIATES, P.A.
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name: ______________________ Date of Birth: ______________

Address: ____

Phone: ______________________

______________________ may release the following information:

Phone: ______________ **Fax:** ______________

- ☐ Entire Record
- ☐ Financial Records
- ☐ Office Visit Notes
- ☐ Radiology Reports
- ☐ Labs
- ☐ Psychotherapy Notes
- ☐ HIV/AIDS Results
- ☐ Other: ______________

Office or Person(s) who will receive this information:

Name(s): ____

Address: ____

City, State, Zip: ______________________ Phone: Fax:

The above approved information may be released to the designated office and person(s) by the following means:

- ☐ Personal Release (In person or by phone)
- ☐ Fax
- ☐ Mail

• I understand that this Authorization shall be in effect until such time as I revoke or revise this Authorization, and that I may do so at any time. I understand that such revocation is not effective if the information has already been disclosed, but will be effective going forward.

• I understand that I have the right to inspect or copy the protected health information as described in this document.

• I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

• I understand that the information disclosed as a result of this Authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

______________________________ ______________

Signature of Patient or Personal Representative Date

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Description of Personal Representative's Authority (attach necessary documentation).