Wiregrass
SURGICAL

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WIREGRASS SURGICAL MEDICAL RECORDS RELEASE FORM

I, _____, DOB _____, hereby authorize the disclosure of my individually Protected Health Information (PHI) as described herein. I understand that this authorization is voluntary and I may cancel this consent at any time in writing to Wiregrass Surgical Associates, P.C. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my right to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Wiregrass Surgical Associates, P.C.

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

This authorization is for release of medical records, financial transactions and other patient-related information including examination, diagnosis, treatment, results, operative notes and/or other reports.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether or not I sign this authorization. I understand that I have a right to inspect and obtain a copy of any information disclosed.

I understand that according to Alabama State Law that there may be a charge for medical records. The fee is as follows: $1.00 for each page up to 25 pages, $0.50 for each page in excess of 25 pages and a search fee of $5.00. Also, reasonable costs shall include the actual mailing costs of mailing the medical records.

I hereby release Wiregrass Surgical Associates, P.C. and its employees from any and all liability that may arise from the release of information as I have directed.

Purpose of Release: **Medical Care** **Legal** **Insurance** **Other**

Specific Items or Time of Service Needed: _____

Patient Signature (or Personal Representative): _____

Date: _____

Requested From: _____

Release To: _____

Fax to Number: **334-793-6840** **or** **334-673-0794** **or** **334-944-4238**

WS EMPLOYEE WITNESS _____