ALABAMA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPPA) and the Alabama Department of Public Health Office of Emergency Medical Services Rule 420-2-1-.13.

Please review and complete the authorization form carefully. Failure to provide all of the requested information may invalidate the authorization.

Patient Information

Patient Name (first middle last): _____

Incident Date: _____ Incident Number (if known): _____

Incident Location: _____

Requesting Parties Information

Name of Requestor: _____ Phone: _____

Company/Organization: _____ Email: Address: _____

Address:_____ Fax: _____

Relationship to Patient:
☐ Self ☐ Parent of Minor ☐ Parent of Disabled Adult ☐ Legal Guardian ☐ Beneficiary
☐ Executor of Estate ☐ Subpoena ☐ Patient Authorized Representative ☐ Power of Attorney
☐ Representing Attorney ☐ Law Enforcement ☐ Spouse/Significant other ☐ Other: _____

You MUST provide a copy of the legal authority you have to make medical decisions for the patient listed on the medical report. If the patient is deceased a copy of the death certificate must be included with request.

Format of Record Release

I request the record to be released in the following manner: ☐In Person ☐Mail ☐Email ☐Fax

Limitation on the Type of Information to Disclose:
☐No limitations on the type of information to disclose ☐Limited to:_____

Patient Authorization

By submitting this form, I hereby voluntarily authorize the release this medical record. As the patient, if I am authorizing the release of my medical record to the representative noted above, I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure. I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. If you are the parent of a minor and represent as such, you agree to hold harmless from damages regarding the disclosure. I hereby understand and agree that requests for electronic copies of my medical records in electronic form via email may not remain confidential due to the unsecure nature of email transmission. I further understand and agree that employees and/or agents are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system. I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been disclosed.

Patient Signature: _____ Date:_____

Or, Signature (not patient): _____ Date:_____

Substantiating Information

Please submit the following with your request:

- A clear copy of your Driver's License or Government Issued Identification Card. This is to be included with request regardless of whether or not you are the patient. (Exceptions are made for Representing Attorney and Law Enforcement only).
- Documentation of legal representation/responsibility if you are not the patient.