

**OB/GYN Associates of Alabama, P.C.**  
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I authorize the release of my medical records to:**

<input type="checkbox"/> <b>Dr. John C. Foster</b>	<input type="checkbox"/> <b>Dr. William M. Johnson, III</b>
<input type="checkbox"/> <b>Dr. Rupa D. Goolsby</b>	<input type="checkbox"/> <b>Dr. Jodie B. Benton</b>
<input type="checkbox"/> <b>Dr. Rebecca H. DeRosier</b>	<input type="checkbox"/> <b>Dr. Mary B. Adams</b>

**800 St. Vincent's Drive**  
**North Tower Suite 600**  
**Birmingham, Alabama 35205**  
**205-271-1600 Office Phone**  
**205-271-3167 Office Fax**

**The disclosure will be made to the following Entity: (Former Doctor)**

**Physician or clinic name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**The type and amount of information to be used or disclosed:**

- Problem and Medication List**
- Immunization Record**
- Hospital Records**
- Laboratory and Diagnostic Results**
- Consultation Reports**
- Entire Records**

**Other:** \_\_\_\_\_

**I hereby authorize the use or disclosure of information about the above named individual and I understand that:**

- 1. This information about me is protected under Federal Law.**
- 2. I may refuse to sign the authorization.**
- 3. I have the right to revoke this authorization in writing.**
- 4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.**
- 5. Unless I revoke this authorization, it will expire on the following date \_\_\_/\_\_\_/\_\_\_, event or condition:\_\_\_\_\_.**  
**If I fail to specify an expiration date, event or condition, this authorization will expire in six months.**
- 6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship of Personal Representative to the Patient**

\_\_\_\_\_  
**Signature of Witness**