AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION IN ALABAMA

I, _____, authorize
(Name of patient)

_____
(Name or general designation of program making disclosure)

to disclose to _____the
(Name of person or organization to which disclosure is to be made)

following information: _____
(Specific nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to: _____
(Specific purpose of disclosure)

_____

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing as follows:

_____.

(State the procedure for submitting written revocation [i.e., the position title and address of the person to whom the revocation needs to be delivered].)

I understand that the covered entity seeking this authorization may not conditioning treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

[OR, where conditioning is appropriate, substitute the above paragraph, such as:
I understand that the covered entity seeking this authorization is permitted under the HIPAA regulations, in accordance with 45 C.F.R. Section 164.508(b)(4), to condition my signing of this authorization on the provision of treatment, payment, enrollment in the health plan or eligibility for benefits, and that by refusing to sign this authorization, I may be faced with the following consequences:

_____.

(State consequences)]

I understand that I am entitled to receive a copy of this authorization after it is signed.

Dated: _____

_____
Signature of patient

_____
Signature of parent, guardian, or authorized representative, when required

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