Authorization to Disclose Protected Health Information

I, the undersigned, authorize
Coastal Neurological Institute
3280 Dauphin St., Bldg. A - Mobile, AL 36616
Ph. 251-450-3700 Fx. 251-450-4492
to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

Section must be filled out completely for request to be processed.

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Please forward the Records by: ☐ Mail ☐ Fax (For Doctor's Office Only!)
Will be mailed unless otherwise noted

Information to be Released

☐ Please provide a **1 year** abstract of my records (includes most recent notes, labs, diagnostic testing)

☐ Please provide a **2 year** abstract of my records

☐ Please provide my **entire** record

☐ **Other** (please specify): _____
_____
_____
_____

I understand I will be responsible for the charges incurred in the release of my protected health information. The following fees may apply: *Search fee: $5.00 per Request*
Copy fee: $1.00 per page for the first 25 pages
$0.50 per page, thereafter.
(See AL Statute Section 12-21-6.1)
Records being sent to another healthcare provider will be provided at **no cost**.

Please provide an email address to have invoice sent. If you do not have an email, an invoice will be mailed to address provided above.

_____

Authorization to Release Protected

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (initials of Patient or Legal Representative)
I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I can request a copy of this form after I sign and date it.

*Please confirm that you have initialed the protected information categories above, regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

***Verified identity by: (Please check the applicable box below or provide further explanation)**
☐Driver's License ☐Military I.D. ☐ (Proof of Legal Guardian, Attorney of Record, Insurance) ☐Other: _____