RELEASE

Total Sports and Family Care
4205 Balmoral Drive, Suite 200
Huntsville, AL 35801
256-382-7767
Fax: 256-880-5262

Karen L. Allen, M.D. **Darla R. Cowart, M.D.**

Authorization of Release of Protected Health Information

Patient's Name:_____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS# _____ Patient's Phone #:_____

Date of Request:_____ Date information needed:_____

I authorize:

☐ Karen L. Allen, M.D.
☐ Darla R. Cowart, M.D.

To release my protected health information identified below to:

_____
Name of Patient, Provider or Facility

_____
Address

_____
City, State, Zip Code Phone Fax

Purpose for the disclosure:

_____

_____

_____

Specific description of information to be disclosed (including dates):

_____

_____

_____

- I understand that I may change my mind and revoke (take back) this Authorization at any time in writing, except to the extent that the persons authorized above, have already acted based on this Authorization, as provided in the Total Sports Care Notice of Privacy Practices.
- I understand that PHI disclosed based on this Authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.
- I understand that PHI disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that Total Sports and Family Care may not condition my treatment on my execution of this Authorization of Release of Protected Health Information.
- I understand that this Authorization expires one year from the date of signature, or sooner as indicated by date I write in here:_____.
- I acknowledge that Total Sports and Family Care (select one): _____ will _____ will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

_____ _____
Signature of Patient or Guardian Date