COMPLETE
WOMEN'S CARE OF ALABAMA

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Medical Record Release

Patient Name: _____ DOB: _____

I authorize Complete Women's Care of Alabama PC (previously Shelby OB/GYN) to use or disclose the above-named individual's health information as described below.

Select the type of information and list the date(s), if applicable.

- ❑ Entire Record
- ❑ Pap Smear Results
- ❑ Office Visit Notes
- ❑ Ultrasound/Mammography Reports
- ❑ Hospital Admissions
- ❑ Laboratory Results
- ❑ Consultation Reports
- ❑ Ultrasound/Mammography Images
- ❑ Other _____

This information may be disclosed to, or used by, the following individual/organization:

❑ I am requesting to **SEND** my records to: ❑ I am requesting my records **FROM**:

Physician/Practice Name: _____ Fax: _____
Address: _____ Phone: _____

Charges according to Alabama law: $5.00 retrieval fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter, PLUS the cost for mailing, $6.50 Disk (includes the cost for mailing)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. If I do not specify otherwise, this release will expire ninety (90) days from the date of my signature below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. If I have questions about disclosure or my health information, I can contact Brian Culverhouse, Privacy Officer.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient