BIMA
Birmingham Internal
Medicine Associates, PC

MEDICAL RECORD REQUEST

Patient Name: _____

SS# _____ DOB_____

I authorize ___

_____

_____

To use the above named individual's Health Information as described below.
The type and amount of information to be used or disclosed is as follows:

□Most recent office notes/labs for referral physician
□X-ray and imaging reports
□Lab Results
□Consultation reports

Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
This information may be disclosed to and used by the following individual or organization:

Birmingham Internal Medicine Associates, PC

7191 Cahaba Valley Road, Suite 300 Birmingham AL 35242

Fax# 205-930-2063

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocations to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date,___, event or condition: If I fail to specify an expiration date, even or condition, this authorization will expire in six months.

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 in order to assure treatment. In understand that I may inspect or copy the information to be used or disclosed, as provided in CRF-164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer.

Date: _____ Patient's Signature_____

Witness: _____