Doctor: _____
MR#:_____

BIMA
Birmingham Internal Medicine Associates, PC

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

***I hereby authorize the use of disclosure of my individually identifiable protected health information ("PHI") as described below. This Authorization includes any information relating to drug and /or alcohol abuse /treatment, communications with psychiatrists or psychologist or records pertaining to sexually transmitted diseases, if they are a part of my medical record.***

**PATIENT'S NAME: _____PATIENT'S DOB: _____**

| **PERSON/ORGANIZATION PROVIDING MEDICAL RECORDS:** | **PERSONS/ORGANIZATION REQUESTING MEDICAL RECORDS:** |
|---|---|
| **Name:**_____ | **Name: _Birmingham Internal Medicine Associates, P.C.** |
| **Address:** _____ | **Address: _7191 Cahaba Valley Road, Suite 300_____** |
| **City, State, Zip:** _____ | **City, State, Zip Code: _Birmingham, AL 35242_____** |
| **Phone:** _____ | **Phone: _(205) 995-9909_____** |
| **FAX:** _____ | **FAX: _(205) 930-2063_____** |

**DATE(S) OF INFORMATION TO BE DISCLOSED: FROM_____ TO_____**

**INFORMATION REQUESTED:**

☐ **ENTIRE RECORD** ☐ **OFFICE NOTES** ☐ **MEDICATION LIST** ☐ **CONSULTATION REPORTS** ☐ **IMAGING REPORTS** ☐ **OTHER**

***(PLEASE SPECIFY)*** _____

**PURPOSE OF USE OR DISCLOSURE:** ***(Copy fees may apply):***

☐ **PATIENT'S PERSONAL RECORDS** ☐ **SHARING WITH OTHER HEALTH CARE PROVIDER** ☐ **OTHER**_____

**PATIENT'S RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** *I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this authorization.* ***I understand I may be charged a fee for record copies.*** *In addition, I understand that I do not need to sign this authorization in order to receive treatment. I also am aware that I may revoke this authorization by notifying the disclosing medical records/ health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures; (1) already made in reliance upon this authorization; (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I realize that the information used and/ or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.*

**SIGNATURE OF PATIENT / *LEGAL REPRESENTATIVE: _____DATE: _____**

***IF SIGNED BY LEGAL REPRESENTATIVE, PLEASE STATE RELATIONSHIP TO PATIENT: _____ Date: _____**

****If you are the power of attorney or legal representative for the patient, please provide documentation to the staff.***