



**Patient's Name:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

**Daytime Phone #:** \_\_\_\_\_ **Alternate/Maiden name:** \_\_\_\_\_

I authorize Princeton Baptist Medical Center/BBH to release and/or disclose my protected health information (PHI) as described below:

**Person / Organization receiving information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Specific Information Requested:**

**Dates of treatment:** from: \_\_\_\_\_ to: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Labs                  |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Radiology Reports     |
| <input type="checkbox"/> Operative Report     | <input type="checkbox"/> Pathology Report      |
| <input type="checkbox"/> Consult Note         | <input type="checkbox"/> Progress notes        |
| <input type="checkbox"/> Entire Record        | <input type="checkbox"/> Emergency Room Report |
| <input type="checkbox"/> Other, specify _____ |  |

By initialing next to a category listed below, I specifically authorize BMC to use and/or disclose my highly confidential information. **Initial each category that Princeton Baptist Medical Center/BBH is authorized to release.**

- |   |  |
|---|--|
| <input type="checkbox"/> Mental Health / Psychiatric Records                                      | <input type="checkbox"/> Information about sexual assault        |
| <input type="checkbox"/> Alcohol and/or Drug Abuse Records  | <input type="checkbox"/> Information about child abuse / neglect |
| <input type="checkbox"/> Information about sexually transmitted diseases                          | <input type="checkbox"/> Psychotherapy notes                     |
| <input type="checkbox"/> HIV/AIDS related testing (whether the results were positive or negative) |  |

The purpose for the use/disclosure of the information is:

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Personal use          | <input type="checkbox"/> Legal     |
| <input type="checkbox"/> Physician care        | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Other, specify: _____ |                                    |

Unless otherwise revoked, this Authorization will expire: \_\_\_\_\_.

(Date or Event)

If I fail to specify an expiration date or event, this authorization will expire six months from the date it was signed.

I understand that once BBH discloses my PHI to the recipient, BBH cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.

I understand that according to state and federal law I may be charged a reasonable fee by the releasing facility for the photocopying of the requested records. I understand that BBH may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my PHI.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at BBH; except, however if my treatment at BBH is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case BBH may refuse to treat me if I do not sign this Authorization.

I understand that if I revoke this Authorization, I must send written notice of revocation to BBH's Custodian of Records at the address listed below. The revocation will be effective immediately upon BBH's receipt of my written notice. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

**I may contact Custodian of Records at the address listed below or by email at [HIMPrivacyOffice@bhsala.com](mailto:HIMPrivacyOffice@bhsala.com).**

**I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly and voluntarily authorize BBH to use or disclose my PHI in the manner described above.**

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**If signed by Legal Representative, Relationship to Patient**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

- Please fill out the authorization completely. If sections are blank or incomplete, we may not be able to process your request.
- When submitting your request for medical records, please enclose a copy of your Photo ID.
- If the records are for a patient whom you have Power of Attorney, please enclose a copy of the POA.
- If the records are for a deceased patient, please provide a copy of the Executor of Estate and Death Certificate.

Completed Authorizations and any required paperwork can be mailed to:

Princeton Baptist Medical Center  
ATTN: HIM/Release of Information  
701 Princeton Ave SW  
Birmingham, AL 35211  
Phone: 205.783.3436  
Fax: 205.783.3464

**Authorization to Use and Disclose Protected Health Information**