Shelby Baptist Medical Center
Brookwood Baptist Health.

Pt. label

Patient's Name:_____

Social Security #:_____-_____-_____ **Date of Birth:** _____-_____-_____

Address: _____

Daytime Phone #:_____ **Alternate/Maiden name:** _____

I authorize Shelby Baptist Medical/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: _____

____History & Physical
____Discharge Summary
____Operative Report
____Consult Note
____Entire Record
____Labs
____Radiology Reports
____Pathology Report
____Progress notes
____Emergency Room Report
_____Other, specify_____

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

_____Mental Health / Psychiatric Records
_____Alcohol and/or Drug Abuse Records
_____Information about sexually transmitted diseases
_____HIV/AIDS related testing (whether the results were positive or negative)
_____Information about sexual assault
_____Information about child abuse / neglect
_____Psychotherapy notes

The purpose for the use/disclosure of the information is:
_____Personal use
____Physician care
_____Legal
_____Insurance
____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 Paula Pickens, Custodian of Records at the address listed below or by email at paula.pickens@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. DL__SS Card___Work ID__Other___
· 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:

Shelby Baptist Medical Center
ATTN: HIM/Release of Information
1000 First Street North
Alabaster, AL 35007
Phone (205) 620-7210
Fax (205) 620-8870