1325 Quintard Avenue
Anniston, Alabama 36201
Phone (256) 741-1339

IMMEDIATE FAMILY CARE
OCCUPATIONAL MEDICINE
C.A.R.E.S.
CHEAHA AREA REGIONAL EMERGENCY SPECIALIST

256 Oxford Exchange Blvd.
Oxford, Alabama 36203
Phone (256) 835-0076

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under Federal Law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

_____ ANY AND ALL MEDICAL / PERSONAL INFORMATION _____
TRANSFER OF MEDICAL RECORD FOR TREATMENT

Information that may not be used or disclosed:_____

_____

Whom may we release your medical information to?

☐ Spouse Parent: ☐ Mother ☐ Father ☐ Sibling ☐ Significant Other: Name _____

The name of other specific identification of the person(s), or class of persons, authorized to make the requested use of disclosure:

CARES MEDICAL CLINIC
1325 Quintard Avenue, Anniston, AL 36201
(256)741-1339

The name or other specific identification of the person(s), or class of persons, to whom The Practice may make the requestd use or disclosure:

ARE WE PERMITTED TO LEAVE A MESSAGE ON HOME RECORDER OR CELL PHONE/VOICE MAIL?

☐ Yes or ☐ No Cell/Home Phone #_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure): _____

This information about you is protected under Federal Law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under Federal Law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature / Patient Representative **Date**

As personal representative, I have authority to act for the individual because I am: **POWER OF ATTORNEY OR GUARDIAN:**

_____