## **Patient Information:**

Patient Name:	Social Security	#:DOB:
I hereby authorize East Alabama Medic (check all that apply):		
☐ <u>Use</u> the following health information maintained by East Alabama Medical Center	Disclose the following health information to:	Obtain the following health information from:
Specific description of the health inform	nation to be used/disclosed/obtained	d (include dates of service, type of service, etc.):
This health information is used/disclose put: "At the request of the individual"):	d/obtained for the following purpos	se (if Authorization requested by the patient
If the disclosure is for marketing purpos for the disclosure of health information?	es, will East Alabama Medical Cer	nter directly or indirectly receive remuneration
By providing this Authorization, I under		<del>-</del>
<ol> <li>I understand that the health information and no longers.</li> <li>I understand that I may revoke the writing, but if I do, it will not hat I understand that I will receive a I understand that this Authorizate event (if for research put "None")</li> </ol>	rmation to be released may be subject protected by the Federal Privacy I his Authorization at any time by no ve any effect on uses or disclosures copy of this Authorization form after ion will expire on// "or "End of the research study"):	tifying East Alabama Medical Center in prior to the receipt of the revocation. ter I sign it.  (MM/DD/YR) or upon the following
Paper	Ra	their medical records. Per the Office of Planning
\$0.50 per	page for pages 26+	.00 per film
East Alabama Medical Center utilizes Discove cords will be made to and collected by Discove nedical records dept. If you have any question 77-567-9535. Requests will be mailed to the four are requesting that a copy of your rethen this is provided at no-cost as a courtes	ons as to the bill or the status of your repatient's home address, or may be pic	equest, you may contact Discovery at: ked up at the EAMC medical records dept.
	SCOVERY Support Services for the	charges incurred in processing my request
Patient or Patient's Representative	Signature	Date
Printed Name of Patient's Represen	ntative (if applicable)  Date of the property	ationship to Patient (If to 11)
EAST ALABAMA MEDICAL PATIENT AUTHORIZATION FOR	CENTER	ationship to Patient (if applicable) Patient Identification
DISCLOSURE OF PROTE HEALTH INFORMATI	CTED	

## East Alabama Medical Center Medical Records Patient Authorization Disclosure for Protected Health Information PHOTO ID MUST ACCOMPANY REQUEST.

I. Patient Name		Social Security #	DOB
atient Address	City	StateZip	Phone
II. I hereby authorize East A	labama Medical Center to dis	sclose my health information to:	
□ Name	100		
Address		City	ST ZIP
Fax number	(we only fax to	physician offices and hospitals) Telep	hone number
☐ Release the record to t	he patient indicated abov	<b>'e.</b>	
III. Specific description of the	health information to be disc	closed (include dates of service, ty	rpe of service, etc.)
		purpose (if Authorization reques	sted by the patient put "At the request of
be affected.  C. I understand that the health protected by the federal Price.  D. I understand that I may reveany effect on uses or disclete. I understand that, upon req.  F. I understand that this Authorized signature.  G. I understand that my record format I should initial here.	h information to be released may ivacy Rules. oke this Authorization at any timesures prior to the receipt of the ruest, I may receive a copy of this orization will expire on/	be subject to re-disclosure by the receive by notifying East Alabama Medica evocation.  S Authorization form after I sign it.  _/(MM/DD/YR). If left blan aronic format (CD) and that if I wish to the it is understood that you wish to he	treatment and/or payment obligations will not ipient of the health information and no longer I Center in writing, but if I do, it will not have k, expiration date will be one year from date by o have it in paper ye your records in electronic format.)
Patient or Patient's Representati	ve s Signature	Date	
Printed Name of Patient's Repr	esentative (if applicable)	Relationship to Pat	ient (if applicable)
physician at no cost as a court	esy. These records will be sent to a veother entity, there is a charge for cop	verifiable fax/address for the physician list	lical care, EAMC will provide the records to the led.  of Planning and Budget for the State of Alabama the
Paper \$1.00 per page for pages 1-25 \$0.50 per page for pages 26+ \$1.50 per page for all micro film copie	Radiology CDs/Films \$8,00 per CD \$8,00 per FILM	Electronic Record Same as "per page" in paper forma	Postage t pricing Actual postage costs
Discovery Support Services. Radiology image	s should be picked up in the EAMC !	Medical Records Department. If you have	nts for records will be made to and collected by any questions as to the bill or the status of your ay be picked up at the EAMC Medical Records
I understand that I will be billed by Discovery	Support Services for the charges incu	rred in processing my request and agree to	o pay any and all charges in full:
Patient or Patient's Representative's S	Signature	Date	
OFFICE USE ONLY: Time !	Now: VIA:	Stay Type: CD?	Time Completed: