INTERNAL MEDICINE SPECIALISTS
513 BROOKWOOD BLVD., STE 50
BIRMINGHAM, AL 35209
PHONE- 205-877-2761
FAX- 205-877-2399

Authorization for Use and Disclosure of Protected Health Information

I, _____, hereby authorize_____, its employees and/or agent to use and/or disclose the following information to:

_____

_____

(Specifically describe the information to be used or disclosed)

_____

_____

This protected health information is being used and/or disclosed for the following purpose(s): **(Provide a description of the purpose of each use and disclosure)**

_____

_____

1) ☑ At the request of the individual.
2) Complete if the authorization is for marketing purposes:
   The use or disclosure requested under this authorization ___ will or ___ will not result in direct or indirect remuneration to Internal Medicine Specialists from a third party.
3.) Check one of the following statements below if request is from Internal Medicine Specialists
   ___ I understand that Internal Medicine Specialists may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure exception.
   ___ I understand that if I do not sign this Authorization, Internal Medicine Specialists may not provide services to me because protect information is solely being created for use and/or disclosure to:

_____

This Authorization shall be in force and effective for one year from the date signed below at which time this authorization to use or disclose this protected health information expires. I understand that a reasonable fee may be charged to cover the cost of copying my records.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 513 Brookwood Blvd., Ste 50, Birmingham, AL. 35209. I understand that a revocation is not effective to the extent that Internal Medicine Specialists has taken action or reliance on the Authorization for use or disclosure of the protected health information prior to receipt of my revocation. I understand that upon my request I may see and copy the protected health information described in this Authorization. *I understand that my protected health information may include information concerning sexually transmitted diseases, behavioral and mental health services and treatment for drug and alcohol abuse, and I authorize the release of this information for the purposes stated above.* I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this Authorization. I release and discharge Internal Medicine Specialists. from any and all liability, claims, and causes and actions of any type arising out of the execution of this Authorization.

_____ _____

Signature of Patient Date Printed Name of Patient Date of Birth

_____ _____

Signature of Personal Representative Date Authorizing Authority of Personal Representative