Sawyer Surgery Clinic

101 E. Brunson St. Suite 300
Enterprise, AL 36330
Phone (334) 393-3212
Fax (334) 393-4979

I _____ authorize and request the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and I may cancel this consent any time in writing to Sawyer Surgery Clinic. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized disclosure and, once information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Sawyer Surgery Clinic.

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act.

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether or not I sign this authorization. I understand that I have a right to inspect and to obtain a copy of my information disclosed.

I hereby release Sawyer Surgery Clinic and its employees from any and all liability that may arise from the release of information as I have directed.

Patient Name _____

Date of Birth _____

Social Security Number _____

Address _____

Patient Signature _____

Witness _____

Date _____

Requesting records from _____

Specific items or dates needed: _____

_____

Release to: _____

_____