RESTORATION HEALTH OF SOUTH ALABAMA, INC.

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MEDICAL RECORDS RELEASE

Patient Name: ________________________DOB: ______________Phone #______________________

I hereby authorize Restoration Health of South Alabama to obtain records from:

Physician or Facility: ____

At this address: ____

Phone: _____________________________________Fax: ____________________________________

Purpose for release:

_____Legal _____Insurance _____Treatment _____Other _____Imaging

Date of Services to be released from: _______________ to ________________

Type of records to be released (office notes, procedure notes, labs, imaging, all records, etc.)

AUTHORIZATION TO RELEASE PROTECTED

"I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease."

____ ___________________________

Signature of Patient/Legal Representative Date

I understand this authorization may be revoked in writing at any time, except to the extent that action has taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on year from the date signed below. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability of disclosure of the above information to the extent indicated and authorized herein. I acknowledge that I have read and filly understand this authorization as it applies to me. By my signature, I authorize execution of the terms of this document.

____________________________________ _________________________

Signature of Patient/Legal Representative Date