AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

State Wellness Center
101 South Union Street
Montgomery, Alabama 36104
334-263-8470

☐ I Hereby Authorize the SEIB State Wellness Center & Pharmacy to REQUEST information FROM:

_____

(*Provider name and address)*

☐ I Hereby Authorize the SEIB State Wellness Center & Pharmacy to RELEASE information TO:

Name: _____ Phone # _____

Address: _____

Regarding the Following Patient:

Name: _____ Phone # _____

Date of Birth: _____ SSN# _____

Address: _____

Records to be Released:

Date(s) treatment was received: _____

☐ Consultative Report ☐ History and Physical ☐ Laboratory Report
☐ Operative Report ☐ Pathology Report ☐ Progress Notes
☐ X-Ray Film ☐ X-Ray Report ☐ Entire Record
☐ Other: _____

Purpose of Release:

☐ Continuing care for ongoing treatment ☐ Transfer of Care ☐ Insurance ☐ Personal Use

This authorization expires on the following date, event or condition: _____
If I do not specify any expiration date, event or condition, this authorization will expire in one year.
Statement of Authorization:

- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to the SEIB State Wellness Center and Pharmacy.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the center and their employees cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ _____
Signature of Patient/Legal Representative Date