Drs. Lawaczeck, McKinnon, Feagin, Carter, Gee & Dahl , P.C.

Dr. Wyatt Feagin, Dr. Britton Carter, Dr. Kathleen Gee, Dr. Ashley Dahl

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

Drs. Feagin, Carter, Gee and Dahl
Name of Person/Organization Releasing Information

1009 Montgomery Highway Suite 200 Birmingham, AL 35216
Address City / State / Zip

Phone: 205-397-9400 Fax: 205-397-9455
Phone Number // Fax Number

To Release my Information To:

_____
Name of Person/Organization Receiving Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

Please initial each item below to indicate your understanding:

____ I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and /or treatment for alcohol and drug abuse.

____I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

Relationship to patient: _____