Marshall Medical Centers
Many Reasons. One Choice.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I hereby authorize Marshall Medical Center _____to disclose the following information from the health records of:

PATIENT NAME: _____ **SOCIAL SECURITY NO.** _____

DATE OF BIRTH: _____**PHONE:** _____

ADDRESS: _____

Covering the period(s) of health care:
FROM (date): _____ TO (date): _____

2. Information to be disclosed:

- ☐ History And Physical
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Operative Reports
- ☐ EKG
- ☐ Complete Health Record
- ☐ Prenatal Record
- ☐ Anesthesia Record
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Ultrasound
- ☐ Mammography
- ☐ Nuclear Medicine
- ☐ Special Procedure
- ☐ Photographs, Videotapes, Digital or Other Images
- ☐ Laboratory Tests (please specify) _____ ☐ Other (please specify) _____

If applicable, I also give permission for the following to be disclosed **(please initial):**
_____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
_____ behavioral health services/psychiatric care
_____ treatment for alcohol and/or drug abuse

3. This information is to be released to (if yourself, please write "self") _____ for the purpose of (why do you need these records?)_____.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.

5. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the privacy officer at Extension 6638.

6. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signed: _____
(Patient) (Date)

_____
or (Legal Representative) (Relationship to Patient) (Date)

_____
(Signature of Witness) (Relationship to Patient) (Date)

Patient ID: _____

**Return to: Health Information Management, Marshall Medical Centers,
227 Brittany Road, Guntersville, AL 35976 or fax to 256-894-6636**

MEDICAL RECORD COPYING FEES

To ensure that your records are kept confidential and private, it is necessary for you to sign for your records and provide proof of identity.

If the records are needed for continuing care, there is no charge when records are ***faxed*** directly to your physician or the facility providing treatment. All other patient requests will typically result in fees for the patient. The fees for patient requests are as follows:

$1.00 per page for the first 25 pages
After the 25th page, the charge will be $0.50 per page

☐ **I require notification if the cost of my records exceeds $50.**

Patients will also be responsible for any applicable taxes. Shipping charges (if your records are mailed) will be the responsibility of the patient.

Walk-in requests that require additional time due to volume or offsite storage will generally be processed within two business days.

HealthPort, Inc. is the Release of Information service for this facility.

By signing below, I acknowledge that I was informed of the fees required to obtain copies of my medical records.

Patient Name: _____

Patient Signature: _____
(Or Signature of personal representative)

Date: _____

Patient's Date of Birth: _____