ALABAMA EYE & CATARACT CENTER p.c.

UAB Highlands
1201 11th Avenue South
Suite 501
Birmingham, AL 35205
Phone: 205-930-0930
Fax: 205-930-9050

Marc Michelson, MD **Jennifer Michelson, MD** **Julia Gannon, OD**

ALABAMA EYE & CATARACT CENTER, P.C.
AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date: _____
Patient Address: _____
Patient Phone Number: _____

I authorize the professional office of doctor(s) named above to receive health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions.

1. Medical records requested from: Dr. _____
2. Description of information to be released: O All medical records, or
   O Other: _____
3. To whom information may be released: _____
4. The purpose(s) for the release. If the authorization is initiated by the individual, it is permissible to write "at the request of the individual" as the purpose:
   _____
5. Expiration date for the release: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign the authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note informing us your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____
If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form.
Print Name: _____ Relationship to Patient: _____
Source of Authority: _____