CULLMAN REGIONAL
1912 Alabama Hwy 157
Cullman, AL 35058
256-737-2502 (Main Number)
256-737-2504 (Fax Number)

# Cullman Regional
## Authorization for Use and Disclosure of Protected Health Information (PHI)

**I authorize release of my protected health information to the Receiving Facility by the Releasing Facility as indicated below:**

| **To (Recipient)** | **From (Releasing facility)** |
|---|---|
| **Recipient Name:** _____ | **Name:** Cullman Spine Institute, Robert Ward, MD |
| **Attention**_____ | **Attention:** Cullman Regional Medical Records |
| **Address:** _____ | **Address:** PO Box 1108 |
| **City:** _____ | **City:** Cullman |
| **State & Zip:**_____ | **State & Zip:** AL, 35056-1108 |
| **Phone and Fax #s:** _____ | **Phone and Fax #s:** Phone – 256-737-2502, Fax – 256-737-2504 |

### Please release the following medical/health information:
Patient Name: _____DOB: _____
Patient Address: _____
City:_____ State:_____ ZIP: _____
Date(s) of Service to be released: _____Medical Record #:_____
Social Security Number (last 4 digits) _____Telephone # _____

### Identification of Patient or Personal Representative:
The patient or personal representative must present proof of identification by providing one of the following:
____ Photo Identification ____ Birth certificate ____ Executor or Adm ____ Power Attorney

If you are signing as the personal representative of the patient, you may be asked to submit proof of your authority to act as a personal representative by the Releasing Facility. If Cullman Regional is the Releasing Facility and if the patient is **deceased**, a copy of the death certificate and/or proof of executor/administrator must be present before medical/health information is released.

### Please provide the purpose for this use/disclosure of your medical/health information:
____ Patient/Personal Rep ____ Legal ____ Insurance ____ Other, please specify
_____

### Information to be released:
____ Discharge Summary ____ Emergency Room Record ____ Face Sheet ____ History and Physical
____ Laboratory Reports ____ Operative Reports ____ Pathology Report ____ Entire Medical Record
____ Radiology (x-rays)** ____ Imaging CD ____ HIV/AIDS ____ Emergency Requested Info
____ UB/Acct'g Info*** ____ Other, If other, please specify: _____

_____ **(Initial if requesting)** I understand that if the materials disclosed contain data related to alcohol and/or drug abuse, the information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits making any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such regulations.

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

I understand that if the person or entity that receives my medical/health information is not a health care provider, healthcare clearinghouse or health plan covered by federal privacy regulations that the information used or disclosed according to this authorization may be re-disclosed byt the recipient and my no longer protected by applicable federal or state privacy laws.

I understand that all **x-ray films must be returned within 30 days of issuance.

I understand that according to state and federal law I may be charged a reasonable fee for the photocopying of the requested medical/health information.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

I understand I may revoke this authorization in writing at any time by submitting my revocation to the releasing hospital/provider except to the extent that they have taken reliance on this authorization. The Releasing Facility may require that you send your written authorization to a different address than the Releasing Facility's address listed above. If the Releasing Facility is Cullman Regional, you may revoke this authorization in writing by submitting your authorization to the Cullman Regional, Director of Medical Records at the address listed above for Cullman Regional. This authorization will expire within 90 days if no expiration date is written.

I understand that protected health information will be released as described herein unless otherwise prohibited.

I hereby release the hospital/provider from any liability related to the release of this information to the persons or entities described herein.

If Cullman Regional is the Releasing Facility, I understand that if I am requesting protected health information for an incapacitated patient, my signature certifies that the patient is indeed incapacitated i.e. unable to appear in person for authorization of release of protected health information.

Signature of the patient:_____

Signature of personal representative:_____

Authority of personal representative: _____

Signature of Witness:_____

Date of Authorization: _____Expiration Date/Event: _____
*(This authorization will expire in 90 days)*

(Copy provided to patient or personal representative)

**If request is mailed to Cullman Regional,**
**A copy of photo ID *MUST* be mailed with the request.**