CULLMAN REGIONAL
Urology Clinic

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256-737-2177 (Main Number)
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Cullman Regional Urology Clinic

External Release of Records

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

To (Receiving facility)	**From (Releasing facility)**
Facility Name: _____	**Name:** _____
Attention_____	**Attention** _____
Address: _____	**Address:** _____
City: _____	**City:** _____
State & Zip:_____	**State & Zip** _____
Phone and Fax #s: _____**FAX:**_____	**Phone and Fax #s:** _____

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 _____ Telephone # _____

Identification of Patient or Personal Representative:

The patient or personal representative must present proof of identification by providing one of the following:

____ Driver's License ____ Social Security Number ____ Birth certificate
____ Work Photo Badge ____ Other Photo Identification ____ Notarized Signature
____ Executor or Adm. ____ Power of Attorney
____ Other _____

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 Medical Center 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)**
____ HIV/AIDS ____ Emergency Requested Info
____ Other, If other, please specify: _____
_____

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 Medical Center, you may revoke this authorization in writing by submitting your authorization to the Cullman Regional Medical Center, Director of Medical Records at the address listed above for Cullman Regional Medical Center. 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 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.

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 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 Medical Center 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)