

Alabama Psychiatric Services, P.C.

- Birmingham - 2868 Acton Rd Birmingham, AL 35243
- Birmingham - IOP 956 Montclair Rd Ste 200 Birmingham, AL 35213
- Birmingham - 956 Montclair Rd – Ste 101 Birmingham, AL 35213
- Madison / IOP - 450 Lanier Rd Madison, AL 35758
- Montgomery - 2637 Eastern Blvd Montgomery, AL 36117
- Montgomery - IOP 2629 Eastern Blvd Montgomery, AL 36117
- Tuscaloosa - 825 Rice Mine Rd N. Tuscaloosa, AL 35406
- Tuscaloosa - IOP 505 Energy Center Blvd, Ste 605 Northport, AL 35473
- Eating Disorder Center of Alabama 956 Montclair Rd Ste 210 Birmingham, AL 35213
- Cullman - 409 Second Ave, N.W. Cullman, AL 35055
- Daphne - 1203 U.S. Hwy 98, Ste 2A Daphne, AL 36526
- Decatur - 801 Church Street N.E., Ste 1 Decatur, AL 35601
- Dothan / IOP - 1672 Columbia Hwy Dothan, AL 36303
- Florence - 1410 Glory Way Florence, AL 35633
- Mobile - 1015 Montlimar Dr, Ste A-210 Mobile, AL 36609
- Mobile - IOP 1015 Montlimar Dr, Ste A-180 Mobile, AL 36609

Authorization for the Release of Protected Health Information

This completed form authorizes Alabama Psychiatric Services, P.C. to **release** the following patient information:

Patients' Name: _____ DOB: _____ SS #: _____

I, the undersigned, authorize Alabama Psychiatric Services, P.C. to release the following **specific** patient information: (list)

1. _____
2. _____
3. _____
4. _____

This information is to be released to: (**specific name and address**)

This information is to be used for the **specific** purpose(s) of:

This authorization is valid for the period of one year from the date listed below. The patient signature listed below may revoke this authorization at any time and may refuse to sign the authorization. Upon signature, the patient will be provided a copy of the authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer covered by this rule. The patients' eligibility for benefits, condition of treatment, payment or enrollment in any health plan will not be affected by this authorization. This authorization conforms to 45 CFR – Parts 160 and 164, Dec. 28, 2000.

Patient Signature **Date:** _____

Parent / Patient Representative Signature **Printed Name and Relationship to Patient** **Date:** _____

Witness Signature **Date:** _____