

Alabama Psychiatric Services, P.C.

2868 Acton Road
Birmingham, Alabama 35243

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: _____