

# SHELBY OB/GYN, P.C.

## Medical Record Release

1010 First Street North Suite 350, Alabaster, Alabama 35007

205-664-9995 (phone) 205-621-9327 (fax)

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Photo ID required \_\_\_\_\_

1. I authorize Shelby OB/GYN PC to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- |   |  |
|---|--|
| <input type="checkbox"/> Pap Smear results      | <input type="checkbox"/> Patient account statement |
| <input type="checkbox"/> Entire record          | <input type="checkbox"/> Hospital admissions       |
| <input type="checkbox"/> Office visit notes     | <input type="checkbox"/> Laboratory results        |
| <input type="checkbox"/> Ultrasound/Mammography | <input type="checkbox"/> Consultation reports      |
| <input type="checkbox"/> Other                  |  |

3. This information may be disclosed to and used by the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Charges according to Alabama law:** \$5.00 retrieval fee, Sending \_\_\_ Requesting \_\_\_  
\$1.00 per page for first 25 pages  
.50 per page thereafter  
Plus, costs for mailing the records

4. 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.
5. I understand that I have the right to revoke this authorization at any time. If I do not specify otherwise, this release will expire ninety (90) days from the date of my signature below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have questions about disclosure or my health information, I can contact Diane Beasley, Privacy Officer.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient