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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH
INFORMATION TO THIRD PARTIES**

Patient Name _____
Address _____

DOB _____
SS# _____
Proof of ID _____

By signing this authorization, I authorize Shelby OB/GYN, P.C., to use and /or disclose Protected Health Information (PIH), which may include, but is not limited to, the release of medical, psychological, psychiatric, alcohol, drug abuse and HIV/AIDS information about me to or for the party or parties listed below.

This authorization permits Shelby
OB/GYN, P.C., ___ request ___ send
Facility _____
Address _____

Phone/Fax _____
For the purpose of _____

Charges according to Alabama law:
\$5.00 retrieval fee
\$1.00 per page first 25 pages
\$.50 per page thereafter plus
\$ mailing cost (if applicable)

The following individually identifiable health information may be released:

___ Specific date(s) _____ ___ Prior 12 months ___ All dates
___ Office records ___ Lab results ___ Ultrasounds ___ X-ray results
___ All records ___ Consultations ___ Hospital admission ___ Other _____

Expiration Date/Event: _____ (will expire after 90 days unless specified)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Shelby OB/GYN, P.C., has acted in reliance upon this authorization. My written revocation must be submitted to the clinic's above address, attention Privacy Officer.

Printed name of patient or legal guardian

Signature of patient or legal guardian

Date

Witness