Southview
Medical Group, PC

St. Vincent's Professional Building 3
Suite 300, 833 St. Vincent's Drive
Birmingham, Alabama 35205
(205) 933-4640

Date: _____

Dear: _____

This letter is in response to the request for your medical records. In order for us to process your request, please complete both sides of this form and return it to Southview's Release of Information Department. We have also inserted a copy of our Notice of Privacy Practices (if you have not already received a copy) as an explanation of your rights related to your medical information.

Pursuant to the privacy guidelines, you have a right access (inspect and copy) protected health information that is maintained by Southview Medical Group, P.C. in a *designated record set* that is used, in whole or in part, by Southview Medical Group, P.C. to make a decision about you and the health care services provided to you. A *designated record set* is comprised of your medical and billing records and includes any item, collection, or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for Southview Medical Group, P.C.

Please see below for the charges pertaining to records. Please return this letter, payment, and authorization for to Southview Medical Group, P.C. at 833 St. Vincent's Drive, POB III Suite 300, Birmingham, AL 35205.

Sincerely,

Southview Medical Group, P.C.

I understand that Southview Medical Group, P.C. may deny access to this information under certain circumstances.

I agree that I am financially responsible for the copying charges, including the cost of supplies, labor, and postage associated with my request (if applicable). The charges are calculated based on a $5.00 medical records fee, plus $1.00 per page up to the first twenty-five (25) pages and $.50 per page thereafter, plus actual postage ($_____) for a total $_____to complete this request. I agree to pay all costs associated with this request.

_____ _____

Signature of Patient or Guardian Date

Southview Medical Group, P.C.

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____
Address: _____

1. I authorize Southview Medical Group, P.C. 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)

____Problem List
____Medication List
____List of allergies
____Immunization record
____Most recent discharge summary
____Laboratory results
____X-ray and imaging reports
____Consultation reports

____Patient Account Statement/Billing Records
____Most recent history and physical
____Entire Record
____ _____

From (date) _____ to (date) _____
From (date) _____ to (date) _____
From (doctor's name) _____

3. 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.

4. This information may be disclosed to and used by the following individual or organization:
   Physician: _____
   Address: _____
   Phone Number: _____ Fax Number: _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Office of Southview Medical Group. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

6. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy Officer for Southview Medical Group, P.C.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to patient Signature of Witness

**********For Healthcare Organization Use Only**********

Date Received: _____ Staff Member Processing Request: _____

Patient or Patient Representative Verified by: ___Signature of File ___Driver's License ___Other