Huntsville Reproductive Medicine, P.C.

Andrew J. Harper, M.D.
20 Hughes Road, Suite 203
Madison, AL 35858
Phone (256) 213-2229 Fax (256) 213-9978

Authorization to Release Medical Records/Information

Physician to provide records: _____

Phone # _____ Fax # _____

Address: _____

City, State, Zip: _____

Patient's Name: _____

Social Security # _____ DOB: _____

Person/Facility to receive records: _____

Phone # _____ Fax# _____

Address: _____

City, State, Zip: _____

Release these records:

1. All records generated by this facility (not including records received from other resources) _____
2. Only some portions of records maintained at facility (dates of treatment, etc. specify below) _____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOU MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED, OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the **EXCEPTION** OF:

Initials:
_____ Substance abuse, if any
_____ Psychological or psychiatric conditions, if any

Initials:
_____ AIDS/HIV, if any

Other (please specify) _____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient Name (Print)

_____
Patient Signature Date