Sparks & Favor, P.C.
2006 Brookwood Medical Center Drive
Suite 700
Birmingham, AL 35209
Phone: (205) 397-1286
Fax: (205) 397-2000

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____

I hereby authorize:

_____

_____

_____

To release information to:

Sparks & Favor, P.C.
2006 Brookwood Medical Center Dr.
Birmingham, AL 35209

Circle reason for release of records

Transfer of care Attorney Insurance Company Disability Claim

Other (please specify) _____

Medical Care Dated From _____ to _____

Circle what is to be sent

Complete Record Physician Notes Laboratory Reports

Other (please specify) _____

Information to be released may include all references to the patient's behavioral or mental health, alcohol or substance abuse, sexually transmitted diseases and HIV/AIDS information.

I understand I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Sparks & Favor, P.C.. I understand that 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 when the law provides my insurer the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire six (6) months for the date of signing.

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. I understand that I may inspect or copy the information to be used or disclosed, as provided in ORF 164.524 of the Federal Register Rules and Regulation I understand that any disclosure of information carries with it the potential for an 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 at 205-397-1286 extension 223.

_____ _____

Signature of Patient or Legal representative Date

_____ _____

If signed by Legal Representative, Relationship to patient Date