



# Heritage Medicine

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## General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize the custodian of records of: \_\_\_\_\_ or other person/entity to disclose/release the following information\* (check all applicable):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> All records                  | <input type="checkbox"/> Billing records               | <input type="checkbox"/> Other (describe specifically) |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Abstract/Summary              |  |
| <input type="checkbox"/> X-ray/radiology records      | <input type="checkbox"/> Pharmacy/prescription records |  |

*\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):  
Please send the records listed above to (use additional sheets if necessary):

**Matthew N. Parker, M.D.**  
**Heritage Medicine**  
**5479 Highway 280, Suite 114**  
**Birmingham, AL 35242**  
**(205) 637-3469**  
**(205) 637-3471 (FAX)**

The information may be used/disclosed for each of the following purposes:

- |  |  |
|--|--|
| <input type="checkbox"/> At my request (only the patient can check this box) | <input type="checkbox"/> For employment purposes |
| <input type="checkbox"/> For my health care                                  | <input type="checkbox"/> Other:                  |
| <input type="checkbox"/> For payment/insurance                               |  |

This authorization shall expire no later than: \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the following event \_\_\_\_\_ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of patient (or patient's representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient representative

\_\_\_\_\_  
Representative's relationship to patient, (i.e. parent, guardian, power of attorney, etc.)