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AUTHORIZATION FOR RELEASE OF INFORMATION FOR
PURPOSE REQUESTED BY PHYSICIAN'S OFFICE FROM ANOTHER COVERED ENTITY

I, _____, (DOB)_____, HEREBY AUTHORIZE

_____ , _____
(NAME OF PHYSICIAN/FACILITY) (ADDRESS/PHONE OR FAX NUMBER)

TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO **INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C., at 100 RICE MINE ROAD N., SUITE B, TUSCALOOSA, ALABAMA 35406**:

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED (INCLUDING DATES): _____

_____

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED TO CARRYOUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS FROM INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C. IN THE FOLLOWING MANNER:

_____

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL _____, AT WHICH TIME THIS AUTHORIZATION TO USE OR DISCLOSE THIS PROTECTED HEALTH INFORMATION EXPIRES.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING AT ANYTIME BY NOTIFYING INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C., at 100 RICE MINE ROAD N., SUITE B, TUSCALOOSA, AL 35401. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT INTERNAL MEDICINE ASSOCIATES, PC, HAS RELIEF ON THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

INTERNAL MEDICINE ASSOCIATES OF TUSCALOOSA, P.C., WILL NOT CONDITION MY TREATMENT, PAYMENT, OR ENROLLMENT (IF APPLICABLE) IN A HEALTH PLAN OF ELIGIBILITY FOR BENEFITS, OR WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OR DISCLOSURE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____
(SIGNATURE OF PATIENT OR PATIENT REPRESENTATION) (DATED)

_____
(NAME OF PATIENT OR PATIENT REPRESENTATION)

_____
(DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY)