



Medical Record Chart # \_\_\_\_\_

- TRINITY OFFICE** • Alabama Heart Institute • 880 Montclair Road, First Floor • Birmingham, AL 35213 • 205/599-3500
- BROOKWOOD OFFICE** • Ambulatory Care Center • 2022 Medical Center Drive, Suite 510 • Birmingham, AL 35209 • 205/877-9290
- ADMINISTRATIVE OFFICE** • 1280 Columbiana Road, Suite 100 • Birmingham, AL 35216 • 205/599-3525
- BROOKWOOD WCC** • 2006 Brookwood Medical Plaza, Suite 104 • Birmingham, AL 35209 • 205/877-9290
- SYLACAUGA OFFICE** • 209 West Spring Street, Suite 104 • Sylacauga, AL 35150 • 256/245-5833
- TALLADEGA OFFICE** • 201 Medical Office Park • Talladega, AL 35160 • 256/480-6300
- SHELBY OFFICE** • 1004 1st Street North, Suite 270 • Alabaster, AL 35007 • (205/621-7935
- OTHER - CVA OFFICE** \_\_\_\_\_

## HEALTH INFORMATION MANAGEMENT DEPARTMENT

Authorization for Use and Disclosure of Protected Health Information (Medical Records)

I, \_\_\_\_\_ (Name of Patient) \_\_\_\_\_ (Date of Birth) hereby authorize the use or disclosure of protected health information about me as described below.

The Protected Health Information may be authorized from: \_\_\_\_\_  
*(Name & Address of Sending Facility/Individual)*

The Protected Health Information may be disclosed to: \_\_\_\_\_  
*(Name & Address of Receiving Facility/Individual)*

This protected health information is being used for the following purpose(s): \_\_\_\_\_ .

The specific information that should be disclosed is:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Office Visit          | <input type="checkbox"/> EKG                | <input type="checkbox"/> Radiology Report  |
| <input type="checkbox"/> Cath Report           | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Consultation Report   |   |  |
| <input type="checkbox"/> Other (Specify) _____ |   |  |

In compliance with HIPAA minimum necessary requirement, a "whole" chart request will not be honored.

Please send the requested information to the following fax number:

- |  |  |
|--|--|
| <input type="checkbox"/> Trinity office – (205) 599-3570   | <input type="checkbox"/> Sylacauga office – (256) 245-5717 |
| <input type="checkbox"/> Talladega office – (256) 480-6688 | <input type="checkbox"/> Shelby office - (205) 621-7014    |
| <input type="checkbox"/> Brookwood office – (205) 599-2224 | <input type="checkbox"/> Other _____                       |

This authorization shall be in force and effective for ninety (90) days, from the date of signature. I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to Julia A. McCutcheon, Privacy Officer.

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that the 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 and state law. CVA is not responsible for any information redisclosed by the third party to whom information is furnished under valid authorization. [I understand the CVA cannot condition treatment on my willingness to sign authorization (subject to certain exceptions).]

Printed Name of Patient or Personal Representative \_\_\_\_\_

Signature of Patient or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_