Stewart H. Tankersley, MD
4154 Carmichael Court • Phone (334) 593-0193 • Fax (334) 593-1693

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

The following person or facility is authorized to **RECEIVE** information requested:

Name Stewart H. Tankersley, MD Office/Fax Number Ph: 593-0193 Fax: 593-1693

Address 4154 Carmichael Court City Montgomery State AL Zip 36106

The following person or facility is authorized to **RELEASE** protected health information:

Name _____ Office/Fax Number _____

Address _____

City _____ State _____ Zip _____

The information to be disclosed *(if you choose specific medical information please list the items needed):*

Complete Medical Record _____ Specific Medical Information_____

For the Purpose of: _____

Example: Changing Doctors · Moving · Claiming Social Security · Wanting a Copy for Own Records

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
I may revoke this authorization by notifying_____ in writing, of my desire to revoke it. However I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
Authorization is in effect for one year from the date signed unless specified below:
This authorization expires on _____, 20____ OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me._____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____	_____	_____
Print Name of Patient /Personal Representative OR Parent/Guardian	Patient's D.O.B.	Patient's Social Security # (Identification purposes only)
_____	_____	_____
Signature of Patient /Personal Representative OR Parent/Guardian	Date	Witness

Description of Guardian's/ Personal Representative's Authority to Act for the Individual

A copy of this completed, signed, and dated form must be given to the Patient or Person signing on the Patient's behalf.
*******There may be a charge for the copying of the medical records.*******