CULLMAN UROLOGY PC

1848 Parkland Drive NE | Cullman, AL 35058
1-256-739-2885

James W. Davis, MD | William H. Parker, MD | Rodney C. Sanders, MD | Nicholas T. Braswell, MD

Authorization for Release of Health Information

Patient Name: _____
Date of Birth: _____
Address: _____
_____

This authorization applies to the following information: (please check one)

_____**ALL** information. I understand that the information may contain psychiatric/ psychological, alcohol/drug abuse, AIDS/HIV information, and /or other sensitive health information.

_____**ONLY** the following records or types of information may be released:

_____

_____

Treatment dates: From _____/_____/_____ to _____/_____/_____

The information may be released as follows: (Please provide address and phone number)

FROM: (Person/Organization)

_____

Address and phone #

_____

TO: (Person/Organization)

_____

Address and phone #

_____

Purpose of release:

Continuity of treatment _____ Other (specify reason) _____

I understand the information released will be limited to information needed to fulfill the need of the disclosure. This authorization is valid for ninety (90) days from the date of signature. I understand I may revoke this authorization in writing at any time by completing a form. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. Before requesting medical record copies, Please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

_____	_____	_____
Parent /Legal Guardian Printed name	Parent /Legal Guardian Signature	Date
_____	_____	_____
Patient Signature if 14 or older	Witness Signature	Date

Records to be received should be mailed to : Cullman Urology, P.C.
1848 Parkland Drive, N.E. | Cullman, Al 35058
Fax:256-739-2885