REQUEST FOR HEALTH INFORMATION

Raynon A. Andrews, M.D., P.C.

Please complete all sections

Patient Name: _____ Date of Birth: _____ SS#: _____

Street Address: _____City: _____ State:_____ Zip: _____

Phone Number: _____ Date of Service: _____

I authorize the use of the above named individuals health information as described below:

1. _____ (Healthcare Provider) is authorized to make disclosure.
2. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.
3. This information may be disclosed to, and used by, the following individual/organization: ***Raynon A. Andrews, M.D., P.C. located at 1878 Jeff Rd, Suite A, Huntsville, AL 35806.***
4. For the purpose of treatment of the patient.
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present it to Raynon A. Andrews, M.D., P.C.. I understand that he revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
7. I authorize all information to be disclosed pertaining to my medical records.

Patient Signature: _____ Today's Date: _____

If Signed by Legal Representative, Relationship to Patient:_____

Signature of Witness: _____ Today's Date: _____