3719 Dauphin Street
P.O. Box 8709
Mobile, AL 36608
251-344-9630

For Internal Use Only
Med Rec Number:______________________ [ ] Inpatient
Account Number:______________________ [ ] Outpatient
Discharge Date:________________

______________________ Name	______________________ Date of Birth
______________________ Address	______________________ Phone Number
______________________ City, State, Zip Code	______________________ Social Security Number

I hereby authorize ____________________________________to release the following information to
Name of Hospital/Healthcare Facility

____
Name of Individual or Facility

- ❑ Abstract (pertinent physician documentation & results)
- ❑ Entire Record
- ❑ History and Physical
- ❑ Discharge Summary
- ❑ Operative Report
- ❑ Other____
- ❑ ER Record
- ❑ Pathology Reports
- ❑ Consultations
- ❑ Physician's Orders
- ❑ Progress Notes
- ❑ Nurses Notes
- ❑ Lab Reports
- ❑ X-ray Reports
- ❑ X-ray Films/CD's
- ❑ Itemized Statement
- ❑ UB-92

Dates of Hospitalization or visit: ____

Purpose of Disclosure: ____

I would like to have my records sent by the following method:
- ❑ Pick-up
- ❑ Mail to: Street Address:____
  City: ______________________________, State:___________ Zip: ______________________
- ❑ Fax to: Fax number: ______________________________
- ❑ Patient Portal: E-Mail Address: ______________________________(***If you elect to use patient portal for electronic delivery of your health information, you, or the recipient listed above, will be provided instructions for setting up an account to access the requested records. Once your account is created, you have direct management and responsibility for your password. If your password is shared with others or used inappropriately once your account is setup, Springhill is not responsible for any resulting disclosures.)***
- ❑ Email: E-Mail Address______________________________

This consent and authorization may include, but is not limited to, the release of medical, alcohol and/or drug abuse treatment, psychological, psychiatric, sexually transmitted diseases, and HIV/AIDS information.

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing and presented to the Medical Records Department. This authorization will expire (i) after 6 months, (ii) after the disclosure is made, or (iii) the date specified here: __________, to accomplish the purpose of the disclosure stated above.

____
Signature of Patient or Representative

______________________________ ____________________
Signature of Witness Date

If signed by a representative, what is the relationship to the patient?
- ☐ Parent/Legal Guardian of a minor child
- ☐ Healthcare Proxy
- ☐ Healthcare Power of Attorney
- ☐ Other:

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45, CFR. Springhill Memorial Hospital may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

REQUEST FOR RELEASE OF HEALTH INFORMATION