

Total Sports and Family Care

4205 Balmoral Drive, Suite 200
Huntsville, AL 35801
256-382-7767
Fax: 256-880-5262

Karen L. Allen, M.D.

Darla R. Cowart, M.D.

Brian A. Cost, M.D.

Jeff Garrard, M.D.

Authorization for Release/Request of Protected Health Information (PHI)

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's Phone #: _____

Date of Request: _____ Date information needed: _____

Sending records out of practice.

| | |
|---|--|
| <input type="checkbox"/> I authorize | <input type="checkbox"/> Karen L. Allen, M.D. |
| | <input type="checkbox"/> Darla R. Cowart, M.D. |
| | <input type="checkbox"/> Brian A. Cost, M.D. |
| | <input type="checkbox"/> Jeff Garrard, M.D. |
| to RELEASE information to: | |
| Name of Provider or Facility | |
| Address | |
| City, State, Zip Code | |
| Phone # and Fax # (Including area code) | |

OR

Requesting records to be sent to practice.

| | |
|---|--|
| <input type="checkbox"/> I authorize: | <input type="checkbox"/> Karen L. Allen, M.D. |
| | <input type="checkbox"/> Darla R. Cowart, M.D. |
| | <input type="checkbox"/> Brian A. Cost, M.D. |
| | <input type="checkbox"/> Jeff Garrard, M.D. |
| to OBTAIN information from: | |
| Name of Provider or Facility | |
| Address | |
| City, State, Zip Code | |
| Phone # and Fax # (Including area code) | |

| | | | |
|---|--|--|--------------------------------|
| Purpose for this request: | | | |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Insurance Coverage | <input type="checkbox"/> Personal | <input type="checkbox"/> Other |
| Type of Records Requested: (check one) | | | |
| <input type="checkbox"/> Specific Information (select one or more, as applicable) | | | |
| <input type="checkbox"/> Consult | <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> X-ray reports | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Other | |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report | | |
| <input type="checkbox"/> All Medical records related to a specific illness or injury: | | | |
| Specify illness/injury: _____ | Dates of treatment: _____ | | |
| <input type="checkbox"/> All Medical Records | | | |

- I understand that I may change my mind and revoke (take back) this Authorization at any time in writing, except to the extent that Total Sports Care, P.C., Brian A. Cost, P.C. or Jeff Garrard, M.D., P.C. have already acted based on this Authorization.
- I understand that PHI disclosed based on this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.
- I understand that PHI disclosed based on this authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnosis and/or treatment of these conditions.
- I understand that this authorization expires one year from the date of signature, or sooner as indicated by date I write in here: _____ (ADD **DATE** TO EXPIRE, **ONLY IF** LESS THAN A YEAR IS DESIRED.)

Signature of Patient or Guardian

Date