Southeast Medical Center / 3365 Skyway Drive, Suite 100 / Auburn, AL 36830
Office: (334) 539-1770 / Fax: (334) 539-1775 / www.southeastmedcenter.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

AUTHORIZATION TO RELEASE INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS: in order for your physician or the staff of **Southeast Medical Center** to give copies of and/or discuss any of your medical record with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so.

In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that rules may be waved.

I authorize **Southeast Medical Center** to release any and all information (including verbal information, copies of any paperwork) concerning my medical care to the following individuals:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

_____ I DO NOT authorize **Southeast Medical Center** to release any information concerning my care to any individual.

_____ I authorize **Southeast Medical Center** to leave a detailed message on the following phone number: _____

_____ I DO NOT authorize **Southeast Medical Center** to leave a detailed message on my answering machine or voice-mail. I acknowledge that by choosing this option that I, the patient, assume full responsibility for contacting **Southeast Medical Center** for the results of all testing.

Printed Patient Name: _____ DOB: _____

Signature of Patient or Parent/Guardian: _____ Date: _____

AUTHORIZATION TO DISCUSS FINANICIAL INFORMATION
In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss finical information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I authorize **Southeast Medical Center** to verbally discuss financial information with:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Printed Patient Name: _____ DOB: _____

Signature of Patient or Parent/Guardian: _____ Date: _____

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how **Southeast Medical Center** may use and disclose my protected health information. I understand that **Southeast Medical Center** reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Signature of Patient or Parent/Guardian: _____ Date: _____