Blossomwood MEDICAL

2121 Whitesburg Dr, Suite C ♦ Huntsville, AL 35801 ♦ www.blossomwoodmedical.com ♦
phone: 883-0107 ♦ fax: 883-0207

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

Patient's Name: _____ DOB: _____
Address: _____
City/Town: _____ State: _____ Zip Code: _____
SSN: _____ Patient's Phone Number: _____
Date of Request: _____ Date Information Needed: _____

☐ **I authorize Blossomwood Medical to:**

RELEASE information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone & Fax Number

OR

☐ **I authorize Blossomwood Medical to:**

RECIEVE information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone & Fax Number

Reason for this request:

☐ Health Care ☐ Insurance ☐ Personal ☐ Other

Type of Records Requested:

☐ Lab Results ☐ Imaging Results ☐ Office Notes ☐ Other

☐ Records relating to a specific date: _____

☐ All medical records

- **I understand that my right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a written request to address provided at the top of this form, except where disclosure has already been made in reliance.**
- **Release of HIV related information, mental helath related care, or substance abuse diagnoses and treatment requires addition authorization.**

_____ _____

Signature **Date**