1705 Main Ave SW Ste B, Cullman, AL 35055 | Phone: (256) 965-0340 | Fax: (256) 965-0341

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME:________________________________ **DOB:** ______________ **SS#:** ______-_____-______

PREVIOUS NAME: ___________________________**ADDRESS:** _______________________________________

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To Whom It May Concern:

I authorize ____

To release my protected health information to and/or from:

Name: Hometown Medical Group – Dr. William R. Turner, Jr. / Leigha Lentini, CRNP / Rebekah Taylor, CRNP

Address: 1705 Main Ave SW Ste B, Cullman, AL 35055

Medical records dated from _______________ to ______________

Please initial all that apply:

______ **Complete Medical Record** – Includes, but is not limited to, demographics, medical history, office notes, hospital records, laboratory reports, test results, radiology images, referrals, consultations, prescription information, and records received from other healthcare providers.

______**Records Related to Behavioral Health and Substance Use** – Includes documentation related to drug or alcohol treatment and/or mental health services.

______**Sensitive Health Information** – Includes STD test results and HIV/AIDS testing results (whether negative or positive). I understand that I must provide written permission before this information is released, and those receiving the information will be made aware of this requirement.

I authorize Hometown Medical Group to release all relevant information, without limitation, regarding any care, treatment, examination, or condition related to me, including any medical, psychiatric, or counseling records.

This authorization shall remain in effect for one (1) year from the date signed below unless revoked in writing. A copy of this authorization shall be considered as valid as the original.

___________________________	___________________________	__________________
Print Name	Signature	Today's Date