2400 E. Avalon Avenue, Muscle Shoals, AL 35661
Phone:256-386-0808
Fax: 256-381-8501

Medical Records Release

Patient Name: _____ Date of Birth: _____

I authorize Avalon Medical Group to transfer the following healthcare information to:

_____

(circle all that apply)

Entire Content of Chart Progress Notes Pathology Notes Lab Reports

Correspondence Operative Reports

Other:_____

I understand that specific information is to be released may include, but is not limited to, history, diagnosis, mental, or psychiatric illnesses, communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), and/or treatment for drug or alcohol abuse. I also understand that revocation and/or withdrawal by me at anytime in writing to the custodian of medical records in this office, except to the extent the action has already been to release the information to the recipient designated above. I have the right to inspect the copy of my health information release, and if I do not sign this release, your office will not release my health information to the recipient designated above. Notice is given to Avalon Medical Group that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatments.

Patient or Guardian Name: _____ Date: _____

Signature: _____ Date: _____