AUTHORIZATION TO RELEASE INFORMATION

By signing this authorization, I authorize the use and/or disclosure of certain protected health information (PHI) about me TO / FROM:

____

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TO / FROM:

Diane R. Counce, M.D.
1000 Southlake Park, Suite 200
Hoover, AL 35244
Phone: (205) 536-8736
Fax: (205) 536-8737

This authorization permits the use and/or disclosure of the following individually indentifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

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The information will be used or disclosed for the following purpose:

________at the request of the individual,

or

____

__ This authorization will remain in effect until rescinded by me in writing.

OR

__ This authorization will expire (give specific date or defined event) ____________________________________

I do not have to sign this authorization in order to receive treatment from Diane R. Counce, M.D. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the address above

________________________ ________________________ ________________________

Today's Date Date of Birth Social Security #

____ ____

Print Patient's Name Relationship if not patient's signature

Patient's Signature ____

ONLY AUTHORIZED REPRESENTATIVES HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION