A R T®

ASSISTED REPRODUCTIVE TECHNOLOGY
ADVANCED REPRODUCTIVE TECHNOLOGY

ART FERTILITY PROGRAM OF ALABAMA
2006 Brookwood Medical Center Drive
Suite 508
Birmingham, AL 35209
205-870-9784; 1-800-476-9784
Fax: 205-870-0698

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Honea, Houserman and Allemand, P.C. to disclose my health information for the following reason(s):

- ❑ Referral to OB/GYN for obstetrical care
- ❑ Referral to another physician for evaluation of _____
- ❑ Requesting a second opinion for _____
- ❑ Other (please specify) _____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying the referring physician listed above in writing, but if I do, it will not have any effect on uses or disclosure prior to the receipt of the revocation.
4. I understand that this Authorization will expire on ____/____/____(MM/DD/YR). Date must be entered!
5. I understand my records may contain Hepatitis and HIV screening results that may be Included in the record release.
6. I understand that I have the right to receive a copy of this Authorization form after I sign it.

There is a processing period of three business days from the time the request is received in the Medical Records Department.

Patient Name (please print): _____

Patient Signature: _____

SS#: _____ DOB: _____

Witness: _____ Date: _____

Release Records To: _____

Address: _____

City / State: _____ Zip: _____