*Kara Wallace, M.D., P.C.*
*204 Lowe Avenue*
*Building 1, Suite 2*
*Huntsville, Alabama 35801*
*256-533-5211*
*256-533-5084 fax*

**PLEASE MAIL THIS FORM TO YOUR PREVIOUS PHYSICIAN**

Patient Name: _____

Date of Birth: ____/____/____ SS#: _____

Address: _____

City, State, Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below:

___ Complete Medical Record

___ Other _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services and treatment for alcohol and drug use and abuse.

This information may be disclosed to and used by the following for the purpose of treatment of the patient:

___ Kara Wallace, M.D., P.C., 204 Lowe Avenue Bldg 1, Ste 2 Huntsville, AL 35801

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician listed as Previous Physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, the authorization will expire on ____/____/____ or if I fail to specify an expiration date, event or condition, this authorization will expire six months from the date of signing.

I understand that one the information is disclosed, the recipient may redisclose it and the information may not be protected by federal privacy regulations.

Signature: _____ Date: ____/____/____

If signed by legal representative, relationship to patient is: _____

Signature of Witness: _____ Date: ____/____/____