Kara Wallace, M.D., P.C.

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Suite 204
Huntsville, AL 35802-1671
256-533-5211
256-533-5084 fax

Patient Name: _____

Date of Birth: ____/____/____

Patient Address: _____
_____

City, State, Zip: _____

Physician/Person to Receive Records:

Physician/Facility: _____

Address: _____
_____
_____
_____

Phone: _____

Fax: _____

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

___ Complete Medical Record

___ Record of care from ____/____/____ to ____/____/____

___ 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.

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 releasing the records. 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.

I understand that once 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: ____/____/____

If this is a permanent transfer of records and care, we would appreciate it if you let us know why you are transferring you records.

____ I am sending selected portions only to a specialist
____ Moving
____ I have had a change of insurance
____ I am changing my primary care physician due to_____