GENERAL SURGERY

Roderick G. Johnson, MD, FACS
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PLASTIC SURGERY

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General Surgery – Phone: 256-237-1624   Fax: 256-241-2277
Plastic Surgery – Phone: 256-237-1625   Fax: 256-241-5400

Medical Records Release

Date:____________________________ Date of Birth:____________________ SSN:_____________________

Patient Name: ____ Maiden Name:_______________________

Request for Medical Purposes

I hereby request that____
Physician or Facility Name

release the requested information to ____
Physician or Facility Name

________Complete Record ______Records dated ______________ to ______________
________Most Recent Mammogram ______Gallbladder Studies
________Recent labs
________Records containing HIV/AIDS, STDs, substance abuse, mental illness/treatment information
________Specific Records as Listed:____

I consent to the release of records containing information regarding the following: HIV/AIDS, STDs, substance abuse, and mental illness/treatment. Initial_______________

Request for Patient Convenience *($10.00 Charge)*

Medical Record / FMLA / Insurance Fax / Mail / Pick up ___________________________________
Fax # or address

This information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

____ ____
Patient Signature or Personal Representative Date

If signed by the patient’s legal representative:

____ ____
Printed Name of Representative Relationship to the Patient

ID verified by: ____________________________

This Authorization is valid until: ____________________________

revised 12/01/2014