PMA
Professional Medical Associates
101 E. Brunson Street, Suite 200
Enterprise, AL 36330
Phone (334) 393-3686 / Fax (334)347-4906

MEDICAL INFORMATION RELEASE

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPPA), we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers, and friends you have designated, about your PROTECTED HEALTH INFORMATION. Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, or mail as needed for your care to only those identified below. Powers of Attorney would be separate from this authorization.

I understand that my medical information may contain information regarding HIV testing and/or treatment, drug or alcohol testing and/or treatment, psychiatric treatment and I authorize their release.

I give my authorization to the following individual(s) to discuss my medical care with my physician and/or staff on my behalf. PLEASE PRINT.

NAMES AND RELATIONSHIP	DATE OF BIRTH	PHONE NUMBER
_____	_____	_____
_____	_____	_____

Please list below any health information that you do not want to be given out:

_____

_____: I DO NOT release my medical information to ANYONE other than myself.

I hereby release Professional Medical Associates, P.C. or any of their agents from legal responsibility or reliability for disclosure of above information to the extent indicated and authorized.

The above information is private and confidential and will be placed in your medical records. This authorization will EXPIRE IN TWELVE (12) MONTHS for the date signed or we receive written notification from you to revoke it.

PATIENT SIGNATURE_____ DATE ____/____/_____

WITNESS SIGNATURE_____ DATE ____/____/_____