GENERAL SURGERY

Roderick G. Johnson, MD, FACS
Lewis E. Sellers, MD, FACS
Richard A. Curtin, MD, FACS
D. DeWayne Clark, MD, FACS
John F. Valente, MD, FACS
John D. Kasper, MD
Judy R. Washington, CRNP

NORTHEAST ALABAMA SURGICAL ASSOCIATES

URQUHART PLASTIC SURGERY

PLASTIC SURGERY

C. Ken Urquhart, MD
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The Surgical Clinic of Anniston, PA
McClellan Park Medical Mall
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PO Box 5430
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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