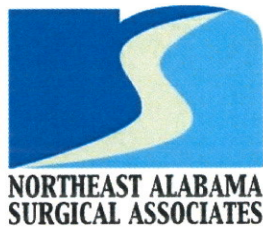


GENERAL SURGERY

Richard A. Curtin, MD, FACS
D. DeWayne Clark, MD, FACS
John F. Valente, MD, FACS
Cynthia M. Hlavacek, MD
Judy R. Washington, CRNP



PLASTIC SURGERY

C. Ken Urquhart, MD
Courtney C. Stellos, CRNP

*The Surgical Clinic of Anniston, PA
McClellan Park Medical Mall
171 Town Center Drive
PO Box 5430
Anniston, AL 36205*

*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: _____