Central Alabama Research
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ____ Date of Birth: _______________________________

I request and authorize:

Name: ____

Address: ____

Phone: ____ Fax: __________________________

To release my healthcare information to Dr. McLean/Central Alabama Research.

Please send the past 5 years of ALL HEALTHCARE INFORMATION.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature: ____ Date: __________________________________

Sending Physician Statement:

I, Dr. _______________________________, confirm that these are certified copies of the medical records for the patient listed above.

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT'S SIGNED