Alabama Physician Health Program

MEDICAL ASSOCIATION of the STATE of ALABAMA

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Medical Director

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Authorization and Consent to Release Information from the Alabama Physician Health Program

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

I hereby authorize and request that the APHP release the following information which may be available:

Records from the following facilities:

_____

_____

Types of Records to be Released:

( ) Assessment/evaluation Findings
( ) Discharge Diagnoses
( ) Discharge Recommendations

( ) Assessment/evaluation Findings
( ) Discharge Diagnoses
( ) Discharge Recommendations

( ) Alabama Physician Health Program Agreement
( ) Urine Drug Screen Report
( ) Other (Please specify) _____

_____

To:

Name _____ Address _____

City/State/Zip _____ Phone _____ FAX _____

I hereby authorize the release of the above information and release and hold harmless the Alabama Impaired Physicians Committee, the Alabama Physician Health Program, its members, agents or employees from any and all claims for damages arising out of or related to the release of the information specified above.

1. **I understand that I have the right to withdraw this authorization at any time, but that this authorization shall expire, without my written revocation, two (2) years from the date provided below except to the extent it is already being relied upon. I authorize a photocopy of this release to be used in lieu of an original signed document.**
2. **The information contained herein is confidential and is being provided in response to this written authorization. Further disclosure by the receiving party is prohibited.**

Date: _____ _____

Signature of Consenting Party

Witness Signature: _____