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 to the Alabama Physician Health Program

______________________________	______________________________
Name	Date of Birth
______________________________	______________________________
Address	City/State/Zip

I hereby authorize and request that the physician(s), hospital(s), or other healthcare provider(s) listed below release to the Alabama Physician Health Program, Post Office Box 1900, Montgomery, AL 36102-1900 the following information:

( ) Assessment/Evaluation Findings
( ) Discharge Diagnoses
( ) Discharge Recommendations
( ) Alabama Physician Health Program Agreement
( ) Urine Drug Screen Report
( ) Other (Please Specify) ______________________________

From:

______________________________	______________________________	
Name	Address	
______________________________	________________	________________
City/State/Zip	Phone	Fax

I hereby authorize the release of the above information and release and hold harmless the physician(s), hospital(s) or other healthcare provider(s), their 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 the source(s) named above will be told that the information they give will remain confidential. I hereby waive my right of access to any information obtained from these sources.
2. 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.
3. The information contained herein is confidential and is being provided in response to this written authorization.

Date: ____________________ ______________________________

Signature of Consenting Party

Witness signature: ______________________________