

Alabama Physician Health Program
MEDICAL ASSOCIATION of the STATE of ALABAMA
19 S. Jackson St., Montgomery, Alabama 36104
334 954-2596 (Phone) staff@alabamaphp.org (Website) 334 954-2593 (FAX)

**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:

Summaries from the following facilities:

Types of Records to be Released:

- _____

 Summary of Assessment/Evaluation Findings*
 Summary of Discharge Diagnoses*
 Summary of Discharge Recommendations*

 Summary of Assessment/evaluation Findings*
 Summary of Discharge Diagnoses*
 Summary of Discharge Recommendations*

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

TO:

Name of Hospital, Company or Individual

Street Address

City, State and Zip

Phone No. & Fax No.

**42 CFR Part 2 – Statutory authority for confidentiality of drug abuse patient records prevents treatment records from being re-released.*

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: _____