



ALABAMA PROFESSIONALS HEALTH PROGRAM

Provided by the Medical Association of the State of Alabama

Authorization and Consent to Release Information to the Alabama Professionals 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 Professionals Health Program, Post Office Box 1900, Montgomery, AL 36102-1900 the following information:

- Assessment/Evaluation Findings
- Discharge Diagnoses
- Discharge Recommendations
- 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: _____