Apex Family Medicine
44 Hughes Road, Suite 2100
Madison, AL 35758
Tel (256) 325-2772 Fax (256) 325-2780

Authorization for Release of Protected Health Records

To_____

_____

_____

I _____ hereby request that you release to:
Afolabi Idowu, MD
120 West Dublin Drive Suite 105
Madison, AL 35758
For the purpose of (provide a detailed description) _____

1. Type of records to be released and date (s) of service

☐ Inpatient ☐Emergency Department
☐Outpatient ☐Physician Office Dates _____
☐Mental Health ☐ Drug and Alcohol

2. Specific Information to be released

☐ Consults
☐ Discharge Summary
☐ Laboratory Report (s)
☐ Mammography report
☐ Emergency Department Record
☐ Physicians Order
☐ Progress Notes
☐ Psychiatric/ Psychological
☐Medical History & Physical
☐ Medication Record
☐ Operative Report
☐ Pathology Report
☐ Radiology Report
☐ EKG Report(s)
☐ Other _____

☐ HIV/STD related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do Not Release

I understand that this authorization is effective for a period of one year from the date of this signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorized above to release the information.

_____ _____
Date of Birth Signature of patient, parent, guardian or personal representative

_____ _____
Witness/ Staff Member Please print name signed above

_____ _____
Date of Signature Relationship to patient