



Southview MEDICAL GROUP, P.C.

ST. VINCENT'S PROFESSIONAL BUILDING 3
SUITE 300, 833 ST. VINCENT'S DRIVE
BIRMINGHAM, ALABAMA 35205
(205) 933-4640

INTERNAL MEDICINE

JOHN E. AMMON, MD
SIMONA S. PETRA DUNLAP, MD
NOAH J. FITZPATRICK, MD
HENRY I. FROHSIN, JR., MD
ROBERT L. GREEN III, MD
DAVID A. HALL, MD
DAVID B. HALL, MD
MICHAEL K. HAN, MD
EDWARD M. KIM, MD
GREG K. LITTLE, MD
C. PETER LICHTY, MD
FRANK J. MALESEK, MD, MBA
LAKISHA MOORE-SMITH, MD, Ph.D
GERALD P. NORRIS, MD
CRAIG J. RICH, MD
MORRIS L. ROEBUCK, JR, MD
DUANE B. SHROYER, MD
JEREMY D. SMITH, MD
MARY ALICE STRAWN, MD
STEPHEN M. STUART, MD
CATHERINE L. THOMAS, MD
JOSEPH E. WELDEN, JR, MD, FACP

CARDIOVASCULAR DISEASE

RICHARD L. COX, JR., MD, FACC
E. MERRITT CULLUM, MD, FACC
F. SPENCER GASKIN, MD, Ph.D.
MONICA HUNTER, MD, FACC, FSCAI
J. MICHAEL PARKS, MD, FACC
RICHARD N. VEST III, MD, FACC, FHRS

DERMATOLOGY

JANET J. CASH, MD, FAAD
TIMOTHY A. MCGRAW, MD, FAAD

ENDOCRINOLOGY

WILLIAM B. MOORE, MD
MARIA S. PRELIPCEAN, MD, FACE
JENNIFER E. SOHN, MD

FAMILY MEDICINE

ELAINE M. COLBY, MD

GASTROENTEROLOGY

CARRIE J. FOLSE, MD
JOSEPH R. NEWMAN, MD
JOANNA L. SIEGEL, MD

INFECTIOUS DISEASE

LELAND N. ALLEN III, MD

RHEUMATOLOGY

THAO NGUYEN TRAN, MD, CCD, RhMSUS

CHIEF EXECUTIVE OFFICER

MICHAEL A. ARLEDGE, MBA

Date: _____

Dear: _____

This letter is in response to the request for your medical records. In order for us to process your request, please complete both sides of this form and return it to Southview's Release of Information Department. We have also inserted a copy of our Notice of Privacy Practices (if you have not already received a copy) as an explanation of your rights related to your medical information.

Pursuant to the privacy guidelines, you have a right access (inspect and copy) protected health information that is maintained by Southview Medical Group, P.C. in a *designated record set* that is used, in whole or in part, by Southview Medical Group, P.C. to make a decision about you and the health care services provided to you. A *designated record set* is comprised of your medical and billing records and includes any item, collection, or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for Southview Medical Group, P.C.

Please see below for the charges pertaining to records. Please return this letter, payment, and authorization for to Southview Medical Group, P.C. at 833 St. Vincent's Drive, POB III Suite 300, Birmingham, AL 35205.

Sincerely,

Southview Medical Group, P.C.

I understand that Southview Medical Group, P.C. may deny access to this information under certain circumstances.

I agree that I am financially responsible for the charge of \$6.50 medical records fee to complete this request. I agree to pay all costs associated with this request.

Signature of Patient or Guardian

Date

Southview Medical Group, P.C.
Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone#: _____

1. I authorize Southview Medical Group, P.C. to use or disclose the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> Problem List	<input type="checkbox"/> Patient Account Statement/Billing Records
<input type="checkbox"/> Medication List	<input type="checkbox"/> Most recent history and physical
<input type="checkbox"/> List of allergies	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Immunization record	_____
<input type="checkbox"/> Most recent discharge summary	
<input type="checkbox"/> Laboratory results	From (date) _____ to (date) _____
<input type="checkbox"/> X-ray and imaging reports	From (date) _____ to (date) _____
<input type="checkbox"/> Consultation reports	From (doctor's name) _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:

Physician: _____
Address: _____
Phone Number: _____ Fax Number: _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Office of Southview Medical Group. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

6. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy Officer for Southview Medical Group, P.C.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to patient

Signature of Witness

*****For Healthcare Organization Use Only*****

Date Received: _____ Staff Member Processing Request: _____

Patient or Patient Representative Verified by: Signature of File Driver's License Other