INFORMATION RELEASE

from Center for Attention & Learning (CAL) to "Other Party"
829 University Boulevard South - Mobile, AL 36609-7873 - 251 342-6443 - FAX 251 342-6566
CAL is an Alabama Professional Corporation.

PRINT PATIENT'S NAME CLEARLY _____ BIRTHDAY _____

Name of "Other Party" : _____ (*person/physician/facility receiving records*)

Full Address of "Other Party" _____

I request & authorize CAL release any and all individually identifiable personal health information (PHI) recorded, possessed, or known by CAL and its professional(s) and/or staff, received from any source. If there are any exceptions, I have listed them on this form. By signing, I specifically authorize release of any/all PHI concerning, stating, or implying: 1. psychiatric, psychological, & mental issues; 2. sexual and/or gender identification, orientation, preference, activity; 3. alcohol &/or other substance misuse or abuse; 4. infectious disease or early stage thereof; 5. criminal or sexual offense.

_____

RANGE OF INFORMATION (refer to the information sheet about our practice closure before you make this decision):

1. ☐ SEND PARTIAL CHART*: Send latest visit reports and other contents CAL feels will likely be the most useful.
***Note: By choosing either partial option,* you: (1) accept the possibility that some record content not selected by you, CAL, or CAL's agents may later be useful, desired, needed, or even necessary to/for you, or to/for another destination, and yet be permanently unavailable; (2) absolve CAL of all responsibility for, and hold CAL harmless for, any and all outcomes or alleged outcomes of its internal selection process; (3) authorize notice to recipient that records provided are incomplete.**

2. ☐ SEND PARTIAL CHART*: Send only these specific items: _____

_____

Note: Statements which we feel are too vague, such as "Send only ADHD information" or "Send whatever my new doctor needs," void this release and it will not be honored.

3. ☐ SEND ENTIRE CHART

Federal law requires you to state who wants this release and your understanding of why it's needed. Check all that apply.
☐ Myself - for my personal purpose(s) or those of someone for whom I am the legal guardian (no purpose statement needed)
☐ CAL - I understand the purpose is: ☐ Facilitate medical care or: _____
☐ Other party - I understand the purpose is: ☐ Facilitate medical care or: _____
☐ Somebody/someplace else - I understand the purpose is: ☐ Facilitate medical care or: _____

End Date: This authorization ends one year from the date of this release, or on this specific calendar date:_____

I understand and agree that: the purpose(s) above are stated as best as understood by CAL and/or myself; any statement by CAL is not legal advice and is made to help me make an informed decision whether to allow PHI release; it is my responsibility to assess whether "purpose" stated by another party is pertinent, valid, legal, or appropriate; it is my responsibility to decide whether I should sign this release; CAL is not responsible for determining the accuracy of any information provided to it.

I know I have the right to refuse or limit this release. I know that when information is released, it leaves control of its source and may be redisclosed properly or improperly by destination or others. I hereby release CAL and its professional and non-professional staff members who provide PHI, from all liability and responsibility arising from any subsequent use, re-release, or alleged misuse of PHI by any party to whom such information becomes available.

I authorize the CAL to release my PHI by any means it feels appropriate, including but not limited to: 1. speech, telephone, fax, computer, modem, or the like over any network useful for delivery of data or information; 2. production or reproduction of documents and/or information and delivery of such by any means including but not limited to physical transmittal by US Mail, commercial carrier, individual, or similar entity (chosen by CAL, patient, responsible party, destination, Other Party, or 3rd party requesting the release or exchange). I may exclude specific means if I desire.

I understand there may be fees for providing, producing, sharing, or obtaining these records and that payment is required in advance. I understand that delivery mechanisms vary in levels of security/privacy and that, if I choose not to deliver this information personally, I am agreeing to whatever level of security/privacy which another method may use. I agree that a photocopy or faxed or emailed copy of this authorization is as sufficient as the original. I may revoke this authorization in writing except to the extent CAL has acted in reliance upon it. If I wish to revoke, I know I must submit request to the Privacy Officer of CAL, whose name and address may be obtained by asking staff of CAL. I accept full responsibility for any and all outcomes or consequences of release and/or limitations of release this information. I certify I have all needed authority and permission to sign this authorization and give this approval. I have read this form before I signed it, I have received all clarification I need, I understand it, and I know I should ask for & get a signed copy of it.

_____	_____	_____	_____
Patient signature if patient is 14 or older	**Date**	**Parent signature if patient under age 19**	**Date**
_____		_____	
Print the above name		**Print the above name**	**5-24-17a**