Alabama Department of Corrections

Inmate Authorization for Release of Health Records

Inmate Name:	**AIS Number:**	**Date of Birth:**
Institution Releasing Information:	**Date:**	**ADOC Contractor:**

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I authorize and release the Alabama Department of Corrections, the ADOC health contractor(s), and the institution from liability relating to the release of the following information, including protected health information, included in my health record to:

Name / Agency:	**Address:**	**City, State, Zip Code:**

Information to be released: (Please select all records needed)		**From Date:**			**To:**	
	Admission Reports		Discharge Reports			X-Ray Reports
	Operative Summary Reports		Special Studies Reports			Laboratory Reports
	Immunization History		Mental Health Reports*			Psychiatric Summary Reports*
	Drug/Alcohol History and Counseling*		HIV Status and Treatment*			Sexually Transmitted Diseases Status and Treatment*
	Other (specify):					

Purpose for which disclosure is being made:					
	Doctor		Insurance		Attorney
	Other (specify):				

*I understand that my expressed consent is required to release any health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use.
You are hereby specifically authorized to release all health care information relating to such testing, diagnosis, and/or treatment of the aforementioned conditions.

Signature of Patient or Authorized Representative **Date**

I understand health records cannot be disclosed without written consent, except as provided for under federal or state law. This authorization is valid for one year after the date signed and is subject to revocation by me at any time if provided in writing to ADOC, the health contractor(s), or the institution, except to the extent that disclosure has already been disclosed in reliance on this authorization.
State law provides that a reasonable fee may be charged for the production of these records.

Signature of Patient or Authorized Representative **Date**

*Authorized Representative's relationship to patient and authority to act for patient:	