St.Vincent's / St. Clair Professional Office Bld.
7067 Veterans Parkway | Suite 210
Pell City, Al 35125
Direct: **205.405.7348** | Fax: **205.338.0550**

AUTHORIZATION FOR PATIENT INFORMATION

Release of Information

__________ I DO NOT wish to have test results or other medical information released to any person other than myself.

__________ I DO wish to have test results or other medical information released to the following person(s):

NAME ______________________ RELATIONSHIP ______________________

NAME ______________________ RELATIONSHIP ______________________

NAME ______________________ RELATIONSHIP ______________________

NAME ______________________ RELATIONSHIP ______________________

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physician's, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist us in assessing a patient's condition, screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcomes measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

Patient Signature ______________________ Date ______________________

Printed Name ______________________ Doctor ______________________

Witness ______________________ Date of Birth ______________________

ACKNOWLEDGEMENT OF RECEIPT OF BALLARD PAIN & WELLNESS NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge I have received a copy of the Ballard Pain & Wellness Notice of Privacy Practices.

Name (Please Print)	Signature	Date

Office Use Only:
Date Acknowledgement Received: ______________________
or..
Reason Acknowledgement Was Not Obtained: ______________________