

**RELEASE**

**Total Sports and Family Care**

4020 Balmoral Drive, Suite 200  
Huntsville, AL 35801  
256-382-7767  
Fax: 256-880-5262

**Karen L. Allen, M.D.**

**Darla R. Cowart, M.D.**

**Brian A. Cost, M.D.**

**Jeff Garrard, M.D.**

**Authorization of Release of Protected Health Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

SS# \_\_\_\_\_ Patient's Phone #: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Date information needed: \_\_\_\_\_

I authorize:

Karen L. Allen, M.D.

Darla R. Cowart, M.D.

Brian A. Cost, M.D.

Jeff Garrard, M.D.

**To release my protected  
health information identified  
below to:**

\_\_\_\_\_  
Name of Patient, Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

Purpose for the disclosure:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific description of information to be disclosed (including dates):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I understand that I may change my mind and revoke (take back) this Authorization at any time in writing, except to the extent that the persons authorized above, have already acted based on this Authorization, as provided in the Total Sports Care Notice of Privacy Practices.
- I understand that PHI disclosed based on this Authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.
- I understand that PHI disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that Total Sports and Family Care may not condition my treatment on my execution of this Authorization of Release of Protected Health Information.
- I understand that this Authorization expires one year from the date of signature, or sooner as indicated by date I write in here: \_\_\_\_\_.
- I acknowledge that Total Sports and Family Care (select one): \_\_\_\_\_ will \_\_\_\_\_ will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date