BALDWIN COUNTY
SURGERY CENTER
USA HEALTH

Patient Request to Inspect or Copy Protected Health Information

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____ Phone Number: _____

Release My Protected Health Information To: (Check One)

(☐) **Myself (Patient)**	(☐) **Baldwin County Surgery Center**	(☐) **Individual/ Business Noted Below:**
	21890 State Highway 181 Fairhope, Alabama 36532 Phone # 251.517.4284 Fax # 251.650.1871	Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____

Information To Be Disclosed:

□ All My Medical Records	□ Clinic Notes (outpatient)	□ Progress Notes (inpatient)
□ History & Physical	□ Operative/Procedure Reports	□ Discharge Summary
□ Laboratory Reports	□ Pathology Reports	□ Cardiology/EKG Reports
□ Radiology Reports	□ Film/CD (Imaging)	□ Patient Billing Records
□ Consultations	□ Other (describe in detail): _____	

We may be prohibited from making certain information available to you or to your representative, including:
Psychotherapy notes, Information related to medical research in which you have agreed to participate, Information related to legal proceedings, Information obtained under a promise of confidentiality, Information that federal or state laws prevent us from disclosing, Information related to medical research in which you have agreed to participate, or Information for which the disclosure may result in harm or injury to your or to another person

Format Requested/Delivery Method:

□ Pickup	□ Inspect
□ Fax to: (251) 650-1871	□ Email to: PAT@baldwincountysurgery.com
□ Mail paper copies to: (Address listed above)	□ Fax to: (Number listed above)

Your Rights with Respect to This Request:
Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide you with a written explanation of any restriction on the information that we can provide you.

Expiration:
Unless written revocation, this Authorization shall remain in effect for one (1) year from the date of signature.

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. *(Initial one:) I do_____ do not_____ agree that any information about such diagnosis or treatment may be released.

_____ _____
Printed Name of Patient or Legal Representative Date

_____ _____
Signature of Patient or Legal Representative/Relationship Date