The Oaks
Family Healthcare LLC

Kimberly F. Owens, M.D.
2298 E. University Dr., Suite A-301
Auburn, AL 36830

Patient Name: _____ DOB: _____

1. I authorize Oaks Family Healthcare, LLC to Request, Use or Disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____

_____

Specified Dates and Providers to be Included:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

From (doctors' names) _____

Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ☐ **Requested From** ☐ **Disclosed To and Used by** the following individual or organization:

Name: _____

Address: _____

For the purpose: _____

☐ At the request of the individual Phone number _____ Fax Number _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Dr. Kimberly F. Owens, Privacy Officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

STAFF MEMBER REQUESTING RECORDS: _____