MADISON
PRIMARY CARE

A Family Clinic

Authorization for Release / Request of Protected Health Information

Patient's Name: _____ DOB: _____
Address: _____
City: _____ State: _____ ZIP: _____
SSN#:_____ Patient's Phone #:_____

Signature of Patient/Guardian: _____ Date of Request: _____

Note: Please be aware that if your medical records reflect any history of alcohol abuse, drug abuse, Psychiatric care or communicable disease, this information will be released as part of your Medical Records.

Please Send All Faxes To: MPC 256-774-5523; For Questions Call: 256-774-5524

☐ I Authorize Madison Primary Care to **RECIEVE** information from:

_____

Name of Provider or Facility:

_____

Address:

_____

City, State, ZIP:

Phone: _____

Fax: _____

☐ I Authorize Madison Primary Care to **RELEASE** information to:

_____

Name of Provider or Facility:

_____

Address:

_____

City, State, ZIP:

Phone: _____

Fax: _____

Reason for this request: ☐ Healthcare ☐ Insurance ☐ Personal ☐ Other

Type of Records Requested: ☐ All Medical Records

☐ Consult ☐ Lab Results ☐ Imaging Results ☐ Discharge Summary ☐ Office Notes
☐ History and Physical ☐ Operative Report ☐ Other: _____
☐ Only Medical Records Related to a Specific Illness or Injury and Date: _____

Adeel A. Bodla, MD | Fakhra Ahmad-Bodla, CRNP
3776 Sullivan Street, Suite D, Madison, AL 35758
Office 256-774-5524 | Fax 256-774-5523
www.MadisonPrimaryCare.com