# Records Request for Incoming Records
# Innova Primary Care, PC

247 Chateau Drive Huntsville, AL 35801-6401
Ph: 256-882-1510 Fax: 256-217-5838

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: _____ Date of Birth: _____
Contact Number: _____

I request and authorize (External Doctor's Name) _____ of (External Clinic Name) _____ in (State Name) _____ to release healthcare information of the patient named above to:

**Innova Primary Care, PC**
**Fax #: 256-217-5838**

☐ Last year of provider progress notes ☐ Labs from past year ☐ Diagnostic Imaging

☐ Immunizations ☐ Colonoscopy ☐ Pap Smear/HPV testing

Other: _____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. _____ (initial)

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. _____ (initial)

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Innova Primary Care, PC. I understand that the revocation will not apply to information that has already been released to this authorization. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]

**Patient's Signature: _____ Date: _____**