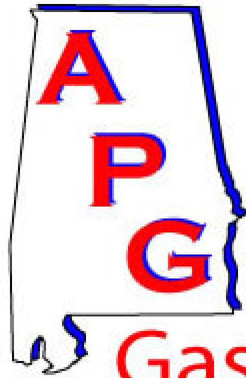

CARY P. CAVENDER, M.D.
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2151 HIGHLAND AVE SOUTH
SUITE 225
BIRMINGHAM, AL 35205
PHONE: 205-933-5744
FAX: 205-933-6666

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO A HEALTH CARE PROVIDER

PATIENT INFORMATION:

Patient Name: ____

Date of Birth: ____

Street Address: ____

City/State/Zip: ____

COVERED ENTITY AUTHORIZED TO RELEASE INFOMATION:

Name: ____

Address: ____

FORWARD INFORMATION TO:
ALABAMA PEDIATRIC GASTROENTEROLOGY, PC
2151 HIGHLAND AVE SOUTH, SUITE 225
BIRMINGHAM, AL 35205

The information below will be used for patient care. (Description of PHI needed)
This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to disclosure another time by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have3 the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the Alabama Pediatric Gastroenterology Office Manager.

____ ____________________________

Signature of Patient/ if minor, Legal Guardian | Date of Signature