

Cahaba Valley Surgical Group, PC

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Chart # _____

Date of Birth: _____ Social Security Number: _____

I hereby give permission to **Cahaba Valley Surgical Group, P.C.**, located at 644 2nd Street North, Shelby Medical Building Suite 206, Alabaster, Alabama 35007 (Dr. Rex A Sherer, Dr. Tim L Christopher, and Dr. Charlie Braswell) to release and/or obtain medical records to or from physician practices, hospitals, or insurance companies that are involved in my care, or for the routine treatment, payment, or healthcare operations of the practice.

Patient information may include (but may not be limited to) the following documents:

- ❖ Labs and diagnostic tests
- ❖ Pathology
- ❖ Radiology
- ❖ History and Physical Data
- ❖ Database Information
- ❖ Financial Information
- ❖ Complete Records of the Patient File

This authorization shall be in effect for as long as I am a patient of Cahaba Valley Surgical Group, P.C.

Or

This authorization shall expire on ____/____/2____.

Signature of Patient or Authorized Parent or Guardian

Date Signed: _____