

CAHABA VALLEY SURGICAL GROUP, PC

205-620-9065 FAX: 205-664-5510

Rex A. Sherer, MD Richard D. Stahl, MD Tim. L. Christopher, MD Vince W. Gardner, MD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name **(Please print)** _____

Date of Birth: _____ Social Security _____

I hereby give permission to **Cahaba Valley Surgical Group, P.C.**, located at 644 2nd Street NE 2nd Street NE, Suite 206, Alabaster, AL 35007 to release my medical records to **UAB Hospital's Gastrointestinal Surgery and General Surgery department**. I intend to follow Dr. Richard Stahl for follow-up care related to my bariatric surgery.

Release to:

Self/Patient: _____

Due to the volume of patients following Dr. Stahl to his bariatric practice at UAB, we are able to produce a copy of records for each patient to pick up here at our office to take to UAB, but we are not able to fax or mail them directly to UAB. The first copy will be produced at no cost to the patient.

You may mail in this request to the address above, or fax it to **205-620-9051**.

Once this release is received, we will process each request within 5-7 business days, and have your records available at our office in Alabaster for pick-up. Please be prepared to bring a driver's license or other photo ID when picking up records.

This request includes all medical records, which include (but may not be limited to) the following documents:

- Labs and diagnostic tests
- Pathology
- Radiology
- History and Physical Data
- Surgical/Operative notes
- 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 ____/____/200____.

Signature _____ Date Signed: _____

