SOUTHERN HEALTH ASSOCIATES, LLC
Todd B. Pearlstein, M.D.
Pamela S. Trantham, M.D.
Stacey J. Jones, CRNP
Katherine Branum, CRNP
P. O. Box 1185
Troy, AL 36081
Phone- 334-566-9800
Fax-334-566-3700

I,_____DOB_____/____/____

Social Security number, _____do hereby authorize and

direct_____from_____
(Name of physician or facility) (Location)

to release a copy of my medical records to Southern Health Associates.

Information requested	Purpose of Requested Use
( ) Complete Medical Records	( ) At the request of patient
( ) Immunizations	( ) Continued Medical Care
( ) Other _____	( ) Other_____

By signing this authorization, I understand as follows:

1. I understand that this authorization is voluntary. I may refuse to sign this authorization And my treatment and /or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the Recipient of the health information and no longer protected by the Federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying Southern Health Associates, LLC, in writing, and if I do it will no effect on uses or disclosures prior to The receipt of the revocation.
4. I understand that if desired, I will receive a copy of this Authorization form after I sign it.

Signature of Patient or Patient's Representative_____

Print Name of Patient or Patient's Representative_____

Representative's Relationship to Patient_____

Witness_____Date of Authorization