

FELLOWS OF THE  
AMERICAN COLLEGE OF SURGERY

AMERICAN BOARD OF SURGERY

AMERICAN BOARD OF  
COLON AND RECTAL SURGERY



# SURGICAL SPECIALISTS

*of Alabama, P.C.*

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DATE: \_\_\_\_\_

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION ("PHI") AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I UNDERSTAND THAT IF THE PERSON OR ENTITY THAT RECEIVES THE INFORMATION IS NOT A HEALTHCARE PROVIDER OR HEALTH PLAN, THE INFORMATION DISCLOSED MAY BE REDISCLOSED AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

PATIENT'S SOCIAL SECURITY NUMBER: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

PERSONS/ORGANIZATIONS RELEASING INFORMATION:

\_\_\_\_\_

ADDRESS OR FAX : \_\_\_\_\_

PERSONS/ORGANIZATIONS RECEIVING INFORMATION: \_\_\_\_\_

ADDRESS OR FAX: \_\_\_\_\_

INFORMATION TO BE DISCLOSED:

\_\_\_ HISTORY & PHYSICAL      \_\_\_ CONSULT REPORT

\_\_\_ DISCHARGE SUMMARY      \_\_\_ LAB

\_\_\_ OPERATIVE REPORT      \_\_\_ X-RAY

\_\_\_ OFFICE NOTES      \_\_\_ ENTIRE RECORD

PLEASE PRINT NAME OF PATIENT: \_\_\_\_\_

SIGNATURE OF PATIENT/REPRESENTATIVE: \_\_\_\_\_

IF REPRESENTATIVE, PLEASE STATE RELATIONSHIP TO PATIENT: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_