PIKE INTERNAL MEDICINE, PC

Peter M. DiChiara, MD, FACP
Jon E. Adams, PA-C, ATC
Jacque Chirico, CRNP
1350 Hwy 231 South
Troy, AL 36081
Phone: (334) 566-1270 | Fax: (334) 566-1296

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Request From:

_____
Provider/Entity

_____
Address

_____
City State Zip Code

Information Requested
(check all that apply)
_____ Complete medical record
_____ Immunizations
_____ Labs or any test results
_____ Other: _____

Purpose of Requested Information
(check all that apply)
_____ At the request of the patient
_____ Continued medical care
_____ Other: _____

Patient's Name: _____
First M. Last

Date of Birth: _____ **SSN:** _____

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPPA privacy rule. I do not have to sign this authorization in order to receive treatment from Pike Internal Medicine. I have the right to revoke this authorization in writing at any time except if Pike Internal Medicine has acted in reliance upon this authorization.

_____ _____
Signature of Patient Date

_____
Address

_____ _____
City State Zip Code Phone Number

This authorization expires 90 days from date of authorization!