

Valley Internal Medicine & Family Care

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Due to Federal Privacy Laws we are unable to provide information to anyone except you, the patient, regarding medical conditions, prescriptions, appointment times, or any other information held by the practice without your specific permission.

If you desire your spouse, friend, parent, etc. to pick up prescriptions, check on appointments, receive lab results or discuss your private medical information, please list him/her/them below and sign/date the authorization.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, Date of Birth: _____,
hereby authorize Valley Internal Medicine to release information from my medical records to include but not limited to my complete medical records, prescription information, appointment or visit information, x-rays and x-ray results, tests and test results, laboratory results to the above named person/persons.

I understand that this consent can be revoked at any time except to the extent of disclosure made in good faith has already occurred in reliance on this consent.

Valley Internal Medicine & Family Care, its employees and officers and attending physicians are released from legal responsibility or liability for release of the above information to extent authorized herein.

Signed: _____ Date: _____