ALABAMA STATE BAR ADMISSIONS OFFICE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This packet contains two (2) Authorization to Release Medical Information forms. One form is for use by the Alabama State Bar (ASB) and the other is for use by the National Conference of Bar Examiners (NCBE). If you were prompted to submit the Authorization to Release Medical Information form, please complete and have notarized both forms – ASB and NCBE. A separate set of forms is required for each service provider (i.e., physician, counselor) and each institution (i.e., treatment facility, hospital).

These forms must be returned in their original format to the following address:

Alabama State Bar
Attn: Admissions
P.O. Box 671
Montgomery, AL 36101

For more information, you may contact the Admissions Office at (334) 269-1515.

DO NOT ALTER THIS FORM
Corrections/erasures VOID this form
Please use black or blue ink

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
ALABAMA STATE BAR (ASB)

*Applicant's name*_____

*Name of institution, doctor, or counselor*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Country*_____ *Province*_____

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol concerning advice, care, or treatment provided to me, to representatives of the Alabama State Bar who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of law. I understand that any such information as may be received will be reported only to the Alabama State Bar. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below. A photocopy of this form is acceptable for purposes of obtaining this information. I hereby release, discharge, and exonerate the Alabama State Bar, its agents and representatives, and the above named provider, its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of any documents, records, and other information, or out of the investigation made by the Alabama State Bar.

I am not required to sign this authorization in order to receive treatment from the above provider. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the privacy officer at the address of the provider above.

_____

Signature of Applicant *Date*

STATE/DISTRICT OF_____

COUNTY/PARISH OF_____

Subscribed and sworn to or affirmed before me this_____day

of _____, _____
Month *Year*

_____

Signature of Notary Public

My commission expires_____

Seal or stamp must be affixed to each original.

The Alabama State Bar is aware of HIPAA requirements.

DO NOT ALTER THIS FORM
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION
NATIONAL CONFERENCE OF BAR EXAMINERS (NCBE)

*Applicant's name*_____

*Name of institution, doctor, or counselor*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Country*_____ *Province*_____

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol concerning advice, care, or treatment provided to me, to representatives of the National Conference of Bar Examiners who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of law. I understand that any such information as may be received will be reported only to the admitting authority. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below. A photocopy of this form is acceptable for purposes of obtaining this information.

I hereby release, discharge, and exonerate the National Conference of Bar Examiners, its agents and representatives, the admitting authority, its agents and representatives, and the above named provider, its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of any documents, records, and other information, or out of the investigation made by the National Conference of Bar Examiners or by the admitting authority.

I am not required to sign this authorization in order to receive treatment from the above provider. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the privacy officer at the address of the provider above.

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Signature of Applicant *Date*

STATE/DISTRICT OF_____

COUNTY/PARISH OF_____

Subscribed and sworn to or affirmed before me this_____day

of _____, _____
Month *Year*

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Signature of Notary Public

My commission expires_____

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The National Conference of Bar Examiners is aware of HIPAA requirements.