

MEDICAL RECORDS



229 Longtown Road Columbia, SC 29229 (803) 419-4949 • FAX: (803) 419-6445

Authorization for Release of Protected Health Information

Patient's full name at the time of treatment:		
Date of Birth: / Social Security Number:		
Date(s) of treatment:		
Purpose of release:		
I authorize the following provider/entity		to release my health information to:
Recipient/Provider Name:		
Recipient's Address:		
City:	State:	ZIP:
☐ Portal ☐ Mail Record ☐ Pick-up ☐ FAX (to he	ealth provider only)	☐ I request a copy of this authorization
Information To Be Released: (Please check all that apply)		
□ Bill □ Cytology Reports □ Diagnosis List/Patient Identification □ Emergency Department Records □ EKG/Cardiovascular □ Laboratory Report (type) □ Mammography Films □ Occupational Therapy Reports □ Office Notes (type) 1. I understand that if my records contain documentation of alcohol abuse, psy as part of my record.	☐ Pulmonary ☐ Radiology F ☐ Radiology F ☐ Speech The ☐ Other: ychiatric condition, drug ab	Dictation (type) Function Test Film (type) Reports Perapy Reports Perapy Reports Perapy Reports Perapy Reports Perapy Reports
 2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed. 3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form. 4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. 5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form. 6. I understand that a copy or FAX of this document is just as valid as the original document. 7. I understand that this authorization will expire 90 days after signed unless an earlier date is specified here		
Signature of Patient or Authorized Person	Date	Contact Telephone Number
Relationship	Reaso	n Patient is Unable to Sign
PROVIDER USE ONLY Original to Medical Records: / Copy to: / Date Verification Completed By:		