P.O. Box 118008
Charleston, SC 29423-8008

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: ________________________ **Date of Birth:** _______________

Address: __________________________

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Social Security #: ______________________

Home Phone Number: __________________

Work Phone Number: ___________________

I authorize the named provider to release and/or obtain my "protected health information" to:

____ Mail Records to: ____
____ Obtain Records from: ____
____ I will pick up ________________________________

Information for treatment period: From (Date)_______________ To(Date)__________________

Information to be released :(Please check all that apply)

__Patient Identification __Office Notes/Physician Dictation __Laboratory Tests
__EKG/Cardiovascular __Radiology Films Type___________ __Radiology Reports
__Pathology Reports __Physical Therapy Records __Occupational Therapy
__Pulmonary Function Test __Bill __OTHER:________________
This information is being requested for the follow purpose(s):___________________________________

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Sensitive information: I understand that my record may include information relating to acquired immunodeficiency syndrome (AIDS), or HIV. Infection, Psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Signature of Patient or Legal Representative ____

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

Signature of Patient or Legal Representative____

EXPIRATION: I understand that this authorization will expire 12 months after signed unless earlier date is specified here_______________

CHARGES: I understand that there maybe a charge for obtaining the requested information.

____ _______________
Signature of Patient or Legal Representative **Date**