AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1 - Patient Information		
Patient's Legal Name	Date of Birth	Telephone Number
Street Address:	City, State, Zip Code	

Section 2 - Information to Be Released: I authorize the use and disclosure of the protected health information ("PHI") about me that is indicated in the checklist below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified in Section 4.

Approximate Dates of Treatment (Must Be Completed):
(Example: 01/01/2022 – Present)

Specific Information to be Disclosed

- ☐ Entire Medical Records
- ☐ Abstract of Health Information
- ☐ Progress Notes
- ☐ Office Visit Notes
- ☐ ER Notes
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Immunizations
- ☐ Radiology & Cardiology Report
- ☐ Radiology & Cardiology CD/Films
- ☐ EKG
- ☐ Lab Results
- ☐ Operative/Procedure Report
- ☐ Physical/Occupational/Speech Therapy
- ☐ Medication List
- ☐ Billing Records
- ☐ Other (Specify): ______________________________

Section 3: Authorized to Release (FROM): I authorize the release of my PHI from the entity identified below.

☐ The Regional Medical Center
3000 St Matthews Rd
Orangeburg, SC 29118
Fax: (803) 395-4011

☐ The Regional Medical Center Clinics:
Clinic Name: ____________________

☐ Other Facility: ____________________
Address: ____________________

Section 4: Authorized to receive (TO): I authorize the release of my PHI to the entity identified below.

Name and Relationship / Facility and Department	Telephone Number	Fax Number
Street Address:	City, State, Zip Code	

Section 5: Purpose of the Use or Disclosure:
☐ Continuation of Care ☐ Personal Use ☐ Insurance ☐ Legal ☐ Disability

Section 6 Method of Disclosure:
☐ U.S Mail ☐ Fax ☐ CD/DVD ☐ Pick Up with Photo ID

I understand that:
1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
6. My signed (written) authorization will expire in ninety (90) days unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:	
Patient/ Legal Representative Signature:	Date:
Printed Name:	Description of Legal Representation: