ABBEVILLE AREA
MEDICAL CENTER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

***Patient Name**: _____ ***Date of Birth**: _____ ***❑ Picture ID**

1. I authorize ❑ Abbeville Area Medical Center **or** ❑ _____
   to disclose Protected Health Information of the above-named individual to the following individual or group:

   Name/Facility: _____

   Address: _____

2. *** Date records were printed and/or CD was requested:** _____

3. I authorize the disclosure of medical information pertaining to the specified items below:

□ History & Physical	□ Discharge Summary	□ Operative Report(s)	□ Pathology Report(s)
□ Physician Orders	□ Progress Notes	□ Consultation(s)	□ ER Record
□ Nurse's Notes	□ MAR(s)	□ Lab(s)	□ Radiology Report(s)
□ EKG/EEG(s)	□ Stress Thallium/Test(s)	□ Respiratory Report(s)	□ Physical Therapy Record(s)

□ Other: _____

***Date(s) of service requested**: _____ ***Account #**: _____

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I, the undersigned, do hereby authorize the release of my pertinent protected health information to the individual or group above.

This includes specific permission to release medical information pertaining to psychological, psychiatric or other mental impairment(s), drug abuse, alcoholism, or other substance abuse, sickle cell anemia, HIV infection (including AIDS or tests for HIV) or sexually transmitted diseases.

This authorization for release of protected health information will be valid for *ninety (90) days* from the date it is signed. This authorization may be revoked at any and must be in writing. If information has been released before revocation has been received the releasing authority shall not be held liable for its past action(s).

A faxed copy of this release shall be deemed as having the same effect as the original.

Faxing Protected Health Information may be required in certain circumstances. The risk(s) have been explained and I understand the risk(s) involved.

_____ _____

***Signature** ***Date**

_____ _____

***Parent/Legal Guardian (if patient under 18)** ***Date**

_____ _____

***Witness** ***Witness**

*** Must Have Information.**