



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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4 **This information is to be disclosed to the above individual or group for the purpose of:** _____

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.

I understand that any treatment I may receive may not be conditioned on whether I sign this authorization and that this authorization is voluntary.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that unless earlier revoked, this authorization will expire ninety (90) days from the date it is signed. This authorization may be revoked at any time 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**