SOUTHEASTERN REGIONAL MEDICAL CENTER

SOUTHEASTERN HEALTH

Name: _____

MRN #: _____

Account #:_____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize Southeastern Regional Medical Center to disclose the following information from the medical records of:

Patient Name: _____ Date of birth _____
First Middle Last

Address: _____

Telephone: _____ MR#_____ SS#: _____

Please note the date(s) of service being requested: From _____ To_____

Please check the specific information being released (used or disclosed):

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ OT/PT/RT
- ☐ Progress Notes
- ☐ Emergency Room Record
- ☐ Nurses Notes
- ☐ Radiology/Imaging Reports
- ☐ Laboratory/Pathology Reports
- ☐ Physician Orders
- ☐ Medication Records
- ☐ Financial information
- ☐ Entire Record
- ☐ Other (Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease,acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual/organization:

Name: _____ Telephone: _____

Address _____ Fax: _____

Email Address: _____

How should the request information be sent.

☐ Mail to address listed above: ☐ Fax number listed above: ☐ Pick-up in HIM Department ☐ Receive Electronically - MyChart

Purpose of Disclosure:

☐ Medical Care ☐ Legal Review ☐ Insurance Review ☐ Personal Use ☐ Social Services/Disabilty ☐ Other _____

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. **I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that this authorization will expire in 90 days.**

Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorized herein. (Form MUST be completed before signing)

Signature of Patient or Representative Date Time

Witness

Print Name if Representative Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the patient. _____

ID Verified by: ☐ Driver's License _____ ☐ Current Inpatient: ☐ Other:_____

If information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this authorization.

Signature of Minor

For Southeastern Regional Medical Center Use Only

☐ Identification verified ☐ Copy of Authorization given to patient	Notes:
☐ Processed by:	
☐ Processed date:	