Lowcountry Infectious Diseases

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

LOCATIONS: Charleston, Summerville & Mt Pleasant

INFORMATION TO BE RELEASED FROM/TO:

Lowcountry Infectious Diseases
1938 B Charlie Hall Blvd
Charleston, SC 29414
843.402.0227 phone
843.402.0232 fax

INFORMATION TO BE RELEASED FROM/TO:

Name: ______________________________________
Address: ____________________________________
____
Phone: ______________________________________
Fax: ____

Service Dates Restricted to: Start Date ___________________________ End Date___________________________

- By initialing the space(s) below – I authorize the following information to be released/disclosed:
  _____Complete Medical Record

OR

- By initialing the space(s) below – I authorize ONLY the following information to be released/disclosed:
  _____Office Notes _____Radiology/Imaging _____Lab/Pathology _____Prescriptions
  _____Other ____

- By initialing the space(s) below – I authorize the above information released/disclosed to include:
  _____Treatment of Drug & Alcohol Abuse
  _____ Psychological or Psychiatric Impairments
  _____Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS)

- By initialing the space(s) below – I certify (declare) the purpose of the release/disclosure is for:
  _____Medical Review _____Legal Review _____Insurance _____Continuity of Care
  _____Other ____

I understand that I have a right to revoke this authorization at any time by notifying Lowcountry Infectious Diseases in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any revocation does not apply to the acceptable and lawful releases under the Notice of Privacy Practices.

I hereby authorize the use or disclosure of my identifiable health information as described above. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for the release and disclosure of the above information to the extent indicated and authorized herein.

I understand that I may be charged for copies of my records based on Lowcountry Infectious Diseases' policy. Current rates will apply.

PATIENT NAME:____
PLEASE PRINT PATIENT NAME

PATIENT PHONE:______________________

PATIENT BIRTHDATE:__________________

REPRESENTATIVE:____
PRINT LEGAL REPRESENTATIVE NAME & RELATIONSHIP

LEGAL REP PHONE:

LEGAL REP. BIRTHDATE:________________

SIGNATURE: ____
PATIENT - OR - LEGAL REPRESENTATIVE/RELATIONSHIP

DATE:_______________________________

SIGNATURE: ____

DATE:_______________________________