AUTHRELSE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completed in its entirety in order to be considered valid.

Patient Name: ______________________ Date of Birth: ______________________

Medical Record Number: ______________________ Social Security Number: ______________________

☐ I authorize MUSC Medical Center to disclose/release information to:
☐ I authorize MUSC Medical Center to obtain information from:

Name of Individual / Organization: ______________________

Street Address: ______________ City: ______________ State: ________ Zip Code: __________

Phone Number: ______________ Fax Number: ______________ E-mail Address: ______________

The purpose of the disclosure is: ______________________

The type of information to be disclosed is as follows:

☐ films / images ☐ problem list ☐ medication list ☐ physician orders
☐ radiology reports ☐ consultation reports ☐ physician progress note / visit notes ☐ immunization records
☐ nurses notes ☐ history and physical ☐ discharge summary ☐ laboratory results
☐ entire record
☐ abstract (history and physical, consult, lab, radiology report, pathology, discharge summary, operative report)
☐ other ______________________

For dates of service: ______________________

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via (check all preferred methods): ☐ mail ☐ fax ☐ e-mail ☐ other ______

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information, which has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. If I have questions about the disclosure or use of my protected health information, I may contact the MUSC Patient and Family Liaison. The number is (843) 792-5555.

I understand I will be given a copy of this authorization.

I understand that if this information is requested in person I will be asked to provide picture identification (e.g. driver's license). A copy of my identification will be made and attached to this authorization.

______________________ ______________________
Signature of Patient or Legal Guardian / Representative Date

____
Printed Name of Patient or Legal Guardian / Representative

______________________ ______________________
Relationship to Patient, if signed by Legal Guardian / Representative Witness Signature

Description of patient representative's authority: ______________________
(The reason the patient is not signing)

To contact Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 / Attention: Release of Information / Charleston, South Carolina 29425-3490; the phone number is (843) 792-3881.

Original to medical record Copy to patient