Authorization for Release of Patient Information

I hereby authorize and request _____to furnish
(Name of Person/Organization to release information)

_____
(Name of Person/Organization to receive information)

_____
(Address)

Regarding: _____
(Patient Name) *(DOB)* *(Social Security Number)*

Medical information concerning the history, treatment, examinations, and/or hospitalizations for the periods from

_____
(Date of Service)

I understand this information will be used for the following purpose _____

Type of Access Requested

- ☐ Copies of the record
- ☐ Inspection of the record

Medical Information to be Released

- ☐ Abstract/Pertinent Information
- ☐ Emergency Room Record
- ☐ H&P
- ☐ Consultation
- ☐ Operative/procedure report
- ☐ Laboratory Results
- ☐ Imaging/Radiology
- ☐ Cardiac Studies
- ☐ Face Sheet
- ☐ Other _____
- ☐ Mammograms

Name of facility of previous mammogram _____

_____ *initials*

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
For HIV information, I have been offered counseling and have _____ *initials* accepted _____ *initials* declined

I, the undersigned, have read the above and authorized the staff at Oconee Medical Center to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it or as otherwise specified by law. No individual has coerced me into signing this authorization and I am providing this authorization under my own free will. I understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws.

I acknowledge that I have the right to revoke this authorization in writing by contacting the Health Information Management Director at 864-885-7182.

_____ _____
(Date) *(Signature of patient or authorized representative)*

_____ _____ _____
(Relationship to Patient) *(Witness)* *(Time)*

Patient ID provided: _____

Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
_____. If no date is specified, this authorization will expire in six months from date of signature.

11796 DRS