PHOEBE SUMTER MEDICAL CENTER

Medical Record Number: _____
(for internal purposes)

# AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name_____ Last 4 digits of SSN _____
Address_____ City_____ State _____ Zip Code_____
Date of Birth _____ Home Phone _____ Work Phone _____
Email address _____

**1. RECEIVING PARTY AND METHOD OF DELIVERY:** ❑ Mail (Complete info below)
❑ Pick up (List by whom below)

I authorize representatives from Phoebe Sumter Medical Center to disclose the health information as directed below:

Name:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Fax Number (continuing patient care support only)_____

**2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

❑ Complete medical record (Please specify dates of service)_____
OR
❑ Partial Medical Record (Please specify records below)
❑ You must check this box if you are also requesting Radiology Images

| Information | Dates | Information | Dates |
|---|---|---|---|
| ❑ History & Physical | _____ | ❑ Operative reports | _____ |
| ❑ Consultations | _____ | ❑ Pathology reports | _____ |
| ❑ Discharge summary | _____ | ❑ EKG reports | _____ |
| ❑ Lab results | _____ | ❑ Emergency Room Record | _____ |
| ❑ X-rays | _____ | ❑ X-rays CD/Films | _____ |
| ❑ Other (Please specify dates of service): | | | |

**3. PURPOSE OF DISCLOSURE**

❑ Insurance Eligibility/Benefits ❑ Changing Physicians ❑ Personal
❑ Further Medical Care ❑ Legal Investigation / or Action ❑ Inspection/Copying of my records
❑ Other: _____

**4.** By signing below you hereby authorize Phoebe Sumter Medical Center to disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purpose and time period described below. Unless specifically excluded below, information to be disclosed will include all diagnoses and treatments, including psychiatric conditions, drug/alcohol/chemical addiction and/or treatment, HIV/AIDS, and other privileged information. Subject to certain exceptions, you have the right to inspect and receive a copy of protected health information.

This information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization. This authorization will expire after 60 days. You have the right to request and receive a copy of this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____
**Signature of Patient/Parent or Guardian:** Date: Time:

_____ _____
**Printed Name** **Description of Authority to Act for Patient**