Authorization for Release of Protected Health Information

Medical Provider's Name: ______________________________

Street Address: ______________________________

____

Phone and Fax: ______________________________

Patient Name at time of treatment:

____

Date of Birth: ______________________ Social Security Number: ______________________

Street Address: ______________________ City/State/Zip code: ______________________

Telephone #: ______________________ Account #: ______________________

I authorize the above named provider to release my protected health information to:

Recipient Name: **Parkside Women's Centre**
Dr. Judith Hoover

Street Address: **PO Box 5669**

City/State/Zip code: **Aiken, SC 29804** **Phone: 803-649-7746**

Fax information to: 803-649-7730

Information for treatment period: From (date)______________________ to (date) ______________________

Information to be released: (Please check all that apply)

- ☐ Patient History Forms
- ☐ Operative Notes
- ☐ Lab tests
- ☐ Office notes
- ☐ Imaging / CDs
- ☐ Hospital reports
- ☐ Pathology reports
- ☐ Imaging reports
- ☐ Other- specify

This information is being requested for the following purpose (s): ______________________

Sensitive Information: I understand that my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to the above medical provider and that the revocation will not apply to information already released based on this information.

Expiration: I understand that this authorization will expire 12 months after signed unless an earlier date is specified here:___________

Services: I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

______________________________ ______________________

Signature of Patient or Legal Representative **Date**

Description of Legal Representative's Authority (Attach necessary documentation)