Medical MC Center

*Internists + Hospitalists*

**MEDICAL RECORDS**

Lexington Medical Center

2720 Sunset Boulevard
Lexington, SC 29072
(803) 936-7372 • FAX: (803) 936-4102

# Authorization for Release of Protected Health Information

Patient's full name at the time of treatment:_____

Date of Birth:_____ / _____ / _____ Social Security Number: ____ ____ ____– ____ ____– ____ ____ ____ ____

Date(s) of treatment: _____

Purpose of release: _____

I authorize Lexington Medical Center Hospitalists to release my health information to:

_____

Recipient's Address:_____

City:_____ State:_____ ZIP:_____ FAX: ( ) _____

- ☐ Mail Record
- ☐ I will pick-up
- ☐ FAX (to health provider or health plan only)
- ☐ I request a copy of this authorization

**Information To Be Released:** (Please check all that apply)

- ☐ Bill
- ☐ Cytology Reports
- ☐ Diagnosis List/Patient Identification
- ☐ Emergency Department Records
- ☐ EKG/Cardiovascular
- ☐ Laboratory Report (type) _____
- ☐ Mammography Films
- ☐ Occupational Therapy Reports
- ☐ Office Notes (type) _____
- ☐ Pathology Reports
- ☐ Physical Therapy Reports
- ☐ Physician Dictation (type) _____
- ☐ Pulmonary Function Test
- ☐ Radiology Film (type)_____
- ☐ Radiology Reports
- ☐ Speech Therapy Reports
- ☐ Other: _____

_____

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.
6. I understand that a copy or FAX of this document is just as valid as the original document.
7. I understand that this authorization will expire 90 days after signed unless an earlier date is specified here _____.

_____ _____ _____

Signature of Patient or Authorized Person | Date | Contact Telephone Number

_____ _____

Relationship | Reason Patient is Unable to Sign

**PROVIDER USE ONLY**

Original to Medical Records:_____ / _____ / _____ Copy to: _____ / _____ / _____

Date Date

Verification Completed By:_____