LEXINGTON MEDICAL CENTER

2720 Sunset Blvd., West Columbia, SC 29169

Authorization for Release of Protected Health Information

Patient's Full Name at the Time of Treatment:_____

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

Please indicate the type of personal health information release you need by selecting <u>one or both</u> of the following options:

☐ Medical Records Release – Release copies of protected health information – medical records (complete section 1 below and section 3 on page two)

☐ Verbal Communication Release – Permission to verbally discuss protected health information (complete section 2 and section 3 on page two)

Section 1 – Medical Records Release (Release copies of protected health information)

Date(s) of Treatment:_____

Purpose of Release:_____

I authorize the following provider/entity _____ to release my health information to:

Recipient/Provider Name: _____

Telephone:_____ Fax:_____

Address:_____

City:_____ State:_____ ZIP:_____

☐ Portal ☐ Mail ☐ Pick-up ☐ Fax (to health provider only) ☐ I request a copy of this authorization

*Mail completed form to: Lexington Medical Center Attn: Medical Records, 2720 Sunset Blvd., West Columbia, SC 29169

Medical Record Information To Release (Please check all that apply.)

Reports/Notes

☐ ED Notes
☐ History & Physical Exam
☐ Consultations
☐ Operative Reports
☐ Discharge Summary
☐ PT/OT/ST Reports
☐ Physician Office Note
Specify Practice:_____
_____
_____

Test Results/Studies

☐ Lab Tests
☐ Pathology Reports

X-Ray/Radiology

☐ Reports
☐ Films (Type):_____

Cardiac/Respiratory

☐ Catheterization Report
☐ Echocardiogram
☐ EKG
☐ Stress Test
☐ Pulmonary Function Test

Other

☐ Diagnosis List/Coding Summary
☐ Medication List
☐ Immunization Record
☐ Billing Record
☐ Patient Identification Sheet
☐ Entire Medical Record
☐ Abstract of Medical Record
☐ Specify Other:_____
_____
_____

Section 2 – Verbal Communication Release (Permission to Verbally Communicate Protected Health Information)

I agree and offer no objection for the physicians, advanced practice providers and support staff at all Lexington Medical Center physician practices that provide my care to verbally communicate my protected health information to the individuals and entities named below.

PERSON/ENTITY	RELATIONSHIP	TELEPHONE NUMBER

If the patient is not present or is unable to agree or object to the verbal communication of protected health information because of incapacity or an emergency circumstance, the practitioner may use professional judgment to determine whether the disclosure is in the best interest of the individual, and if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care.

Section 3 – Review and Authorize

In Accordance With These Conditions

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/permission at any time, but revocation will not apply to information already released.
   - Medical Records revocations should be sent to: Lexington Medical Center Attn: Medical Records, 2720 Sunset Blvd., West Columbia, SC 29169.
   - Permission for verbal communication revocations can be done at any time by contacting Lexington Medical Center provider/practice either in writing or in person.
4. I understand that I may refuse to sign this authorization and 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 this charge can be obtained by contacting the Medical Records department at (803) 791-2264.
6. I understand that a copy or fax of this document is just as valid as the original document.
7. I understand that this medical record release authorization will expire 90 days after signature unless an earlier date is specified here _____.
8. Unless previously revoked, I understand that this permission to verbally discuss protected health information with persons listed on this form will expire one year from the date of my signature.

_____ _____ _____

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

_____ _____

Relationship | **Reason Patient is Unable to Sign**