

CONWAY MEDICAL CENTER
300 SINGLETON RIDGE ROAD ♦ CONWAY, SC 29526

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	Birth Date:	Phone No.:
Social Security No. (optional) :		

Organization Information

Name of the organization Authorized to <u>Release</u> the Protected Health Information:	Name of the organization Authorized to <u>Receive</u> Protected Health Information:
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Organization Full Address including City, State and Zip:	Organization Full Address including City, State and Zip:
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Organization Phone Number: _____	Organization Phone Number: _____
Organization Fax Number: _____	Organization Fax Number: _____

This authorization will expire in **90 days** unless otherwise specified below:

Purpose of the information (Reason for disclosure):

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Rhythm Strips		<input type="checkbox"/> Billing record:	
<input type="checkbox"/> Consultation Report		<input type="checkbox"/> Nursing Information		<input type="checkbox"/> Radiology Films:	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Clinical Test	
<input type="checkbox"/> Pathology Report		<input type="checkbox"/> ER Information		<input type="checkbox"/> Other:	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Other:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Discharge Instructions			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
 2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
 3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
 4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
 5. If requested, I may receive a copy of this form after I sign it.

Section B: Signatures

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

Patient's Signature:	Date:
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Parent/Guardian/Representative's Signature:	Date:
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