

CONWAY MEDICAL CENTER

P.O. BOX 829 ♦ 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):			
Person or Organization Authorized to <u>Release</u> the Protected Health Information:			Person or Organization Authorized to <u>Receive</u> Protected Health Information:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
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? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> 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"/> Admission form <input type="checkbox"/> History and Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Consultation Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Billing record: <input type="checkbox"/> Radiology Films: <input type="checkbox"/> Clinical Test <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
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 redisclosed. 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:	
Parent/Guardian/Representative's Signature:				Date:	