

Attachment A: Authorization for Use and Disclosure of Protected Health Information

Patient Identification:

Printed Name: _____ Date of Birth _____

Address: _____

Social Security #: _____ Telephone: _____

Information To Be Released-Covering The Periods Of Health Care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please check type of information to be released:

Table with 3 columns: Entire medical record, Pathology report, Discharge summary, History and physical exam, Consultation reports, Progress notes, Laboratory test results/reports, X-ray reports, X-ray films/images, Operative report, Emergency room record, Itemized bill

Other. (specify) _____

Purpose of Request

Table with 3 columns: Treatment or consultation, At the request of the patient, Billing or claims payment

Other. (specify) _____

Person Authorized to Receive Information

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that is my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I agree to its release. Check One: [] Yes [] No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and or treatment, I agree to its release. Check One: [] Yes [] No _____ Initials

Time Limit & Right To Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 258 N. Ron McNair Blvd. Lake City, SC 29560. Unless revoked, this authorization will expire on the following date or event _____ . If no expiration date is set forth this authorization will expire 180 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Lake City Community Hospital may not condition my treatment on whether I sign this authorization form unless specified above under Purpose Of Request. I can inspect or copy the protected health information to be used or disclosed. I Authorize _____ (Name of Facility or Provider) to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to sign if not patient: _____

Identity of Requestor Verified Via [] Photo ID [] Matching Signature [] Other, Specify _____

Verified by: _____