

Authorization for Release of Protected Health Information

Patient Name: _____ **Date of Birth:** _____
Last First M.I. Social Sec. Number: _____

I authorize: _____ To release to: _____
 Presbyterian Hospital of Greenville Address: _____
 Presbyterian Hospital of Commerce _____
 Citizen's Home Health _____
 Other: _____ Phone Number: _____
Fax Number: _____

This information is needed for the purpose of: _____ at the request of the individual
 Medical Care Insurance Litigation Other _____

Date information is needed: _____ Information is to be sent via:
 Patient to pick up records Send by Mail Fax to _____

TREATMENT DATES TO BE INCLUDED: _____ to _____

Please check all applicable information requested:

<input type="checkbox"/> Demographics Sheet	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Medication Records
<input type="checkbox"/> History and Physical	<input type="checkbox"/> MD Progress Notes	<input type="checkbox"/> Diagnostic Imaging Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Diagnostic Imaging Films
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> EKG/Cardiographics	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> ER Records	<input type="checkbox"/> Laboratory Reports	_____

I understand that the information to be released may include information regarding a medical condition which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency, or individual named on this request. I (patient name) _____ authorize the release of information regarding:

Drug Abuse/Dependence HIV Test Results Psychiatric Conditions
 Alcohol Abuse/Dependence HIV/AIDS/ARC infection

I request and authorize the above named health care provider to release the information specified to the organization, agency, or individual named on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expires **180** days from the date signed. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The facility to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

Signature of Patient _____ **Date** _____

Signature of Authorized Party _____ **Date** _____
 Durable Power of Attorney
 Legal Guardian
 Other: _____

If the patient is unable to sign or is a minor, complete the following:

Minor of _____ age
 Unable to sign because: _____

