

Release of Information Authorization

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Phone #: _____ E-mail address _____

NOTE: All items, 1 through 6 must be completed, along with signature and date

1.) Release Records To: (Where do you want the information sent? Who may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
2.) Obtain Records From: (Who has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
3.) Release Instructions: (How do you want the information?)	Release Method / Format Requested: (check one) <input type="checkbox"/> Mail <input type="checkbox"/> My Chart / Epic <input type="checkbox"/> Fax (To healthcare provider ONLY) <input type="checkbox"/> Electronic <input type="checkbox"/> Other _____		
4.) Purpose of Release: (Why is it needed?)	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Patient Request <input type="checkbox"/> Military <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> School <input type="checkbox"/> Other _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by SC Law.		
5.) Treatment Date(s): (When were you seen?)	<input type="checkbox"/> Treatment dates from _____ to _____ (please be specific) OR <input type="checkbox"/> All Treatment Dates		
6.) Information to be Released: (What do you want sent or released? Check the appropriate box)	<input type="checkbox"/> Abstract Information: History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports, Emergency Department Reports	<input type="checkbox"/> Immunization Records <input type="checkbox"/> Medication List <input type="checkbox"/> Physician Progress / Visit Notes <input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychotherapy <input type="checkbox"/> Test Results <input type="checkbox"/> Demographics
<p>I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV /AIDS. This information may have been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. This prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted in written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 160 & 164. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.</p>			
<p>I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from the date of signature unless otherwise specified.</p>			
<p>I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.</p>			
<p>Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)</p>			
<p>Be aware the processing of this document will release the entire medical record requested which may include information from other providers.</p>			

Printed Name of Patient or Legal Guardian / Representative

Date

Signature of Patient or Legal Guardian Representative

Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting Prisma Health to send records, return this form to:

Greenville Market – 255 Enterprise Blvd., Suite 120, Greenville, SC 29615; Phone (864) 454-4600 Fax (864) 454-4654, ROI@prismahealth.org

Columbia Market – HIM Dept, Taylor at Marion Street, Columbia, SC 29220; Phone (803) 296-5865 Fax (803) 296-5869, HIMROI@prismahealth.org