PRISMA HEALTH®

***Retain Original and Provide Patient with A Photocopy** **MR# / SSN:** _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Hereby Authorize Prisma Health to Use or Disclose my Protected Health Information as Described Below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____
First Middle Last

Address: _____ Telephone Number: _____

Social Security Number: _____ Date of Birth: _____

Name of Person/facility Authorized to **RELEASE** the information: _____

Name of Person/facility Authorized to **RECEIVE** the Information: _____

Address: _____ Telephone Number: _____

City, State, and Zip Code: _____ Fax Number: _____

Purpose of Disclosure: _____

Dates of Treatment: _____

Information to be Used/Disclosed – Please check those that apply:

History and Physical	☐	Discharge Summary	☐	Operative Report	☐	Other (specify)	☐ _____
Progress Notes	☐	Laboratory Report	☐	Radiology Report	☐	Immunization Record	☐
Billing Summary	☐	Consultation Report	☐	Pathology Report	☐	Entire Medical Record	☐

Requested Method of Deliver: Paper_____ CD_____ Email_____(eDelivery Form must be completed)

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

Prisma Health may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. **The facility has already acted on your request prior to receiving the request to cancel the authorization; or**
2. **If the authorization was given to release records to your insurance company in order to obtain insurance coverage.**

This authorization will automatically expire in 90 days unless otherwise stated.

_____ _____
Signature of Patient or Legally Qualified Representative Date

_____ _____
Relationship of Legally Qualified Representative Witness

Please Address Correspondence to the Appropriate Address

Prisma Health Baptist Hospital
Health Information Mgmt.
Taylor at Marion Street
Columbia SC 29220

Prisma Health Tuomey Hospital
Health Information Mgmt.
129 N Washington Street
Sumter SC 29150