

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TIDELANDS HEALTH

I authorize: _____ Tidelands Georgetown Memorial Hospital _____ Tidelands Waccamaw Community Hospital _____ Tidelands Health Physician Practices
(Check what applies) 606 Black River Road, 29440-3304 4070 Highway 17 Bypass, 29576-5033
Georgetown, South Carolina Murrells Inlet, South Carolina DR _____
Phone: 843-520-8404; Fax: 843-520-8073 Phone: 843-652-1098; Fax: 843-652-1085 (Please write physician name)

Facility Release To: _____

To release the following information from the health records for:

1. Patient's Name: _____ Patient's Date of Birth: _____

Patient's Social Security Number (Last 4 digits): XXX-XX- _ _ _ _ Patient's Telephone: _____

2. Covering The Periods of Treatment: From: _____ To: _____

3. Information To Be Released As Checked:

_____ Abstract (discharge summary, consultation reports, emergency department reports, history & physical, laboratory reports, operative reports, pathology reports, x-ray reports)	_____ History & Physical	_____ Complete Record
_____ Consultation Report	_____ Laboratory Report	_____ Medication Admin. Records
_____ Discharge Summary	_____ Operative Report	_____ Nurses Notes
_____ Emergency Department	_____ Pathology Reports	_____ Other Diagnostic Reports
_____ Other [Please Specify]: _____	_____ X-ray Reports	_____ Progress Notes
	_____ Cardiac Studies	_____ X-Ray Films/CD

4. Type of Access Requested: _____ Copy of the record/s _____ Inspection of the record/s

5. _____ I understand that this information may include references to or treatment of drug or alcohol abuse, **Initials** psychological illness, or test results for HIV/AIDS.

6. Information Is To Be Released To: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

7. Purpose of Disclosure: _____ Continued Health Care _____ Personal Reasons _____ Insurance _____ Legal _____ Other
(Note: If patient is seeking his/her own records, purpose of disclosure can be left blank)

8. This Authorization expires on _____ or upon the following event: _____
(Date)

(If date/event is not specified, this authorization will expire one (1) year from the date of Signature)

I understand that this authorization may be withdrawn by me at any time as explained in the Tidelands Health Notice of Privacy Practices except to the extent that action has been taken in reliance upon it. I understand that information disclosed under this authorization may be re-disclosed by the recipient of the information and the information may not be given the same protection it receives from the hospital. The facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "**Authorization for Release of Medical Information.**" I understand that I have the right to refuse to sign this authorization and the Hospital may not condition treatment based upon my refusal to sign the authorization unless the authorization is necessary for research related treatment of healthcare related services provided solely for the purposes of releasing the information to a 3rd party.

10. A photo static copy of this authorization is to be considered as valid as the original.

11. Fees/charges will comply with all laws and regulations applicable to release of information.

12. I understand that the Hospital/Dr. office has up to thirty [30] days to provide access to my record for records stored on-site, and up to sixty [60] days to provide access to records stored off-site.

Signature of Patient or Guardian: _____ Date: _____

Patient/Guardian/Requester Picture ID [Copy]: _____ Guardian's Relation to Patient: _____

Documentation of Healthcare Power of Attorney for adult patient or emancipated minor [copy attached] _____

Processed by: _____ / _____ Date _____

Print name of Processing Staff

Signature of processing staff