<u>AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION</u>
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)*

<u>**Facility Release To:**</u>_____

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

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 "<u>**Authorization for Release of Medical Information**</u>." 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 Hosipital/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