Authorization for Release of Medical Information
Tidelands Health

****This form is to be used only when requesting records from a non-Tidelands Health physician's office****

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

Patient's Social Security Number (Last 4 digits): xxx-xx-_____ Patient's Telephone:

The patient listed above is requesting records be released:

To: _____ From: _____
Address: _____ Address:_____
_____ _____

Telephone:_____ Fax:_____ Telephone:_____ Fax:_____

The records released should cover the period of treatment from: _____ to:_____

Information to be released as checked:
_____Complete Record
_____Abstract (discharge summary, consultation reports, emergency department reports, history and physical, laboratory reports, operative reports, pathology reports, x-tray reports)
_____Laboratory Reports _____Operative Reports _____X-Ray Reports
_____Other (please specify) _____

Type of Access Requested: _____copy of records Purpose of Disclosure: _____continued health care

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

This authorization expires on _____ or upon the follow event: _____
(date)
**If date/event is not specified, this authorization will expire one year from the date of signature)*
I understand this authorization may be withdrawn by me at any time as explained in the Tidelands Health Notice of Privacy Practices except to the extent that action has been taken in reliance upon it.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. I understand that I have the right to refuse to sign this authorization and the physician's office 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 third party.

Signature of Patient or Guardian: _____ Date: _____