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
Georgetown, South Carolina
Phone: 843-520-8404; Fax: 843-520-8073

4070 Highway 17 Bypass, 29576-5033
Murrells Inlet, South Carolina
Phone: 843-652-1098; Fax: 843-652-1085

DR________________________
(*Please write physician name)*

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:**

□Entire Record (Excluding radiology images) □ Radiology Images/CD □ Physician progress notes/visit notes
□Abstract (history& physical, laboratory reports, discharge summary, operative reports, emergency report. consultation reports, pathology reports and x-ray reports)
□Other:____

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:____

Email Address____

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. **Record Format:** _______ **CD** _______ **Paper Copy** _________ **Encrypted Email**
*Although Tidelands Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

9**.** 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