

**Authorization for Release of Protected Health Information**

To be completed by the patient or the patient's authorized representative:

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Patient's Name Date of Birth

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Street Address

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City State Zip Code

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Telephone

I hereby authorize Little River Medical Center, Inc. to (check those that apply):

To receive the following protected health information from:

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Name of Physician or Provider

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Street Address

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City State Zip Code

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Telephone Fax

Note: Fax Medical records to Little River Medical Center at 855.711.0315 or mail to P.O. Box 547 Little River, SC 29566.

Or:

- to release my confidential health information, as described below, to:
- me or:

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Name

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Organization Name

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Street Address City

in the following manner

- Copies by mail
- Copies by fax
- Copies to be picked-up
- Inspection
- Other: \_\_\_\_\_

For the following purpose(s): \_\_\_\_\_

My authorization is for the use and disclosure of the following records:

- Medical records
- Pharmacy records
- Billing records
- Mental health records
- Alcohol Drug Treatment Records
- Dental records
- X-rays and other images
- Psychotherapy notes
- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information Sexual Transmitted Diseases (STDs)
- Other: \_\_\_\_\_
- All of the above

My authorization pertains to information generated on the following date(s) or in the following time period

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My authorization is given freely with the understanding that:

I may refuse to sign this authorization

- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that any such revocation is in writing. Revocation must be sent to the attention of the Privacy Officer at 4303 Live Oak Drive, Little River, SC 29566 or by fax to 843-663-8100.
- LRMC may not condition my treatment on my provision of this authorization
- This authorization is valid for a 12-month period from the date it is signed or sooner if so, specified by me, as indicated below
- A photocopy or fax of this authorization is as valid as the original.
- The Health Center, its directors, officers, employees, agents and volunteers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of the Health Center

**This Authorization will expire on:** \_\_\_\_\_

(12 months from date of signature unless otherwise specified)

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Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Signature of Patient's Representative \_\_\_\_\_ Date \_\_\_\_\_

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Description of Personal Representative's Authority \_\_\_\_\_

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LRMC Witness Signature \_\_\_\_\_ Date \_\_\_\_\_