Authorization for Release of Protected Health Information

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

Patient's Name Date of Birth

Street Address

City State Zip Code

Telephone

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

To receive the following protected health information from:

Name of Physician or Provider

Street Address

City State Zip Code

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:

Name

Organization Name

Street Address City State Zip Code

Telephone Fax

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

___

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.
- 1 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)

___

Patient's Signature Date

___

Signature of Patient's Representative Date

___

Description of Personal Representative's Authority

___

LRMC Witness Signature Date