

Patient Information:

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Little River Medical Center to:

SEND INFORMATION TO:

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

In the following manner: copies by mail copies by fax inspection
 Other: _____

Purpose of the Request: New Primary Provider/Moving Legal Health Insurance Change/Financial
 Dissatisfied with Provider/Practice Dual Residencies (not transferring care)
 Other: _____

Specific Records/Reports to be released:

- Please provide the last 2 years of my medical records
- Please provide the last 2 years of my dental records
- Please provide a copy of my full medical record
- Please provide a copy of my full dental record
- X-rays or other images
- Lab Results
- Other (please be specific, include dates and providers): _____

Restricted Authorization to Release Protected Information:



IMPORTANT: It is extremely important that you select either your “DO” or “DO NOT” for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could delay our ability to fulfill your request. Thank you.

- DO** **DO NOT** want **Mental/Behavioral Health** released
- DO** **DO NOT** want **HIV/AIDS Screening Test Results and Information**
- DO** **DO NOT** want information about **Sexually Transmitted Diseases (STDs)** released
- DO** **DO NOT** want information about **Alcohol/Drug Treatment** released.

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 fax 855-711-0315.
- LRMC may not condition my treatment on my provision of this authorization.
- A photocopy, fax, or electronically sent and signed 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 is valid for a 12-month period from the date it is signed or sooner if so, specified by me, as indicated below:

Patient Signature or Signature of Personal Representative's Authority

Date

Description of Personal Representative if not signed by the patient