LRMC LITTLE RIVER MEDICAL CENTER

Authorization for Release of Protected Health Information
Little River Medical Records Department
PO BOX 547 Little River, SC 29566
Phone: 843-663-8000 ext. 8023
Fax: 855-711-0315

Patient Information:

Patient Name: ______________________________

Date of Birth: ______________________ Phone Number: ______________________

Street Address: ______________________________

City: ______________________ State: __________ Zip Code: __________

I hereby authorize Little River Medical Center to:

REQUEST INFORMATION FROM:

Name/Facility: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip Code: __________

Phone Number: ______________________ Fax Number: ______________________

SEND INFORMATION TO:

Name/Facility: Little River Medical Center – Attention Medical Records Department

Address: PO BOX 547

City: Little River State: SC Zip Code: 29566

Phone Number: 843-663-8000 ext. 8023 Fax Number: 855-711-0315

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.

I ☐ DO ☐ DO NOT want **Mental/Behavioral Health** released
I ☐ DO ☐ DO NOT want **HIV/AIDS Screening Test Results and Information**
I ☐ DO ☐ DO NOT want information about **Sexually Transmitted Diseases (STDs)** released
I ☐ 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:

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Patient Signature or Signature of Personal Representative's Authority Date

____
Description of Personal Representative if not signed by the patient