Authorization for the Release of Identifying Health Information

104 Buckwalter Parkway, Unit 1C
Bluffton, SC 29910
Phone: 843.757.9588/Fax: 843.757.9589

Patient Name:____

Patient Phone Number:______________________ DOB______________

Patient Address:____

The professional office named above is authorized to release health information under the terms and conditions:

1. Description of information:
2. Released to:
3. Reason for release:
4. Expires:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how you may request access to your health information, and how we may respond. You simply need send a written request to this office Medical Records, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to Medical Records.

When your health information is disclosed, As provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

We will not receive financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____________________________________ ______________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient:

___________________________________ _________________________

Relationship to patient Print name