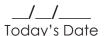
## Authorization for Release of Protected Health Information





EDGEFIELD MEDICAL CENTER

A Department of Self Regional Healthcare Partners

Patient Name		Date of Birth		
Protected Health Information (PHI)	to be released from:			
Entity Name				
Address	City	State	ZIP	
Phone #	Fax #			
Email Address				
about the above patient to the follo	is authorized to release prote owing party below:	ected health informo	ation (PHI)	
Entity Name				
Address	City	State	ZIP	
Phone #	Fax #			
Email Address				
List the medical data or informatior	n that is to be used or disclosed:			
Entire Medical Records				
Progress Notes				
Lab and Test Results				
□ Other:				
Physician Notes				
information will be released as a part of my		-		
2. I understand that if a person or entity receive be protected and may be re- disclosed.	ving this information is not covered by federal privac	y regulations, this informatio	011 W111 110 101	

- 3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocation must be in writing and should be sent to the address noted at the top of this form.
- 4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- 5. I understand that there may be charge for obtaining the requested information. Information on the charge can be obtained by contacting the entity at the top of this form.
- 6. I understand that this authorization will expire one (1) year after signed unless an earlier date, condition, or event is specified.