Authorization for Release of Protected Health Information

__/__/____
Today's Date

SELF REGIONAL HEALTHCARE
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

_____ **is authorized to release protected health information (PHI) about the above patient to the following party below:**

Entity Name

Address | City | State | ZIP

Phone # | Fax #

Email Address

List the medical data or information that is to be used or disclosed:

❑ **Entire Medical Records**
❑ **Progress Notes**
❑ **Lab and Test Results**
❑ **Other:**
❑ **Physician Notes**

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as a part of my record.
2. I understand that if a person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re- disclosed.
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.

Patient/Guardian Signature | Date