Future Use Only

SELF REGIONAL HEALTHCARE

Self Medical Group

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

City/State/Zip: _____

Medical Record # _____ Date of Birth _____

Phone #: _____ Social Security Number: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. Self Regional Healthcare is authorized to make the disclosure.

3. The type and amount of information to be used or disclosed is as follows

   _____ Problem List _____ Medication List _____Allergies
   _____ Immunization Record _____ most recent History and Physical
   _____ Most recent Discharge Summary
   _____Laboratory results from _____20___ to _____ 20_____
   _____X-ray reports from _____20____ to _____ 20____
   _____Consultation reports from (please supply MDs name)_____
   _____ ENTIRE RECORD **DATE OF VISIT** : _____
   _____Other (please describe) _____
   _____
   _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to, and used by the following individuals or organizations:

   Name _____

   Address _____

   _____

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6. This information is being disclosed for the following purposes:
   _____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department of Self Regional Healthcare, 1325 Spring Street, Greenwood, South Carolina 29646. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
   _____
   If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

9. Self Regional Healthcare will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization except if the authorization is for research, Self Regional Healthcare may condition the provision of research-related treatment on you signing an authorization allowing the use or disclosure of your protected health information for such research or if the health care provided by Self Regional Healthcare is solely for the purpose of creating protected health information for disclosure to a third party, Self Regional Healthcare may condition the provision of health care on you providing an authorization allowing the disclosure of the protected health information to such third party.

10. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

11. If I have questions about disclosure of my health information, I can contact the Manager of Health Information Management at 864-725-6030.

12. Photo ID may be required.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by legal representative, relationship to patient

_____ _____
Signature of Witness Date