Form # 37

CONWAY MEDICAL CENTER

P.O. BOX 829 ¨ CONWAY, SC 29526

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:			**Birth Date:**	**Phone No.:**	
			Social Security No. *(optional)*:		
Person or Organization Authorized to Release the Protected Health Information:			**Person or Organization Authorized to Receive Protected Health Information:**		
Address:			**Address:**		
City:	**State:**	**Zip:**	**City:**	**State:**	**Zip:**

This authorization will expire in **90 days** unless otherwise specified below:

Purpose of the information (Reason for disclosure):

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s);	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ Admission form ☐ History and Physical ☐ Discharge Summary ☐ Consultation Report ☐ Operative Report ☐ Pathology Report ☐ Physician orders ☐ Intake/outtake		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information ☐ Medication Sheets		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Billing record: ☐ Radiology Films: ☐ Clinical Test ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. If requested, I may receive a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Patient's Signature:	**Date:**
Parent/Guardian/Representative's Signature:	**Date:**