MUSC Health

AUTHRELSE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Form Origination Date: 1/2000

Version: 11 Version Date: 11/17

Patient Name: _____

Date of Birth: _____

Last 4 digits of SSN: _____

Phone #: _____

MRN (Internal Only): _____

This form must be ***COMPLETED*** in its entirety in order to be considered valid.

MUSC Release Records To: (***Where*** do you want the information sent? ***Who*** may have the information?)	**Individual OR Organization:** _____ **Attention to:** _____ **Address** _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Day Phone Number:** _____ **Fax Number** _____		
Release Instructions: (***How*** do you want the information?)	**Release Method / Format requested: (Check ONE)** ☐ ***Mail*** ☐ ***DVD/CD*** ☐ ***My Chart*** ☐ ***Fax*** **(For healthcare providers / organizations as permitted)** ☐ ***Other*** _____		
Purpose of Release: (***Why*** is it needed?)	☐ **Continuing Care** ☐ **Legal** ☐ **Patient Request** ☐ **Military** ☐ **Insurance** ☐ **Disability** ☐ **School** ☐ **Other** _____ **I understand that fees for copies of medical records/Images and postage fees may be charged as provided by S.C. Law.**		
Treatment Date(s): (***When*** were you seen?)	☐ Treatment dates from _____ to _____ (Please be specific) **OR** ☐ All Treatment Dates		
Information to be Released: (***What*** do you want sent or released? Check the appropriate box.)	☐ Entire Medical Record **OR** ☐ Abstract Information History & Physical, consults, lab & radiology reports, discharge summary, operative/procedure reports, Emergency Department reports, and Occupational /Physical Therapy reports.	☐ Radiology Images / DVD (**NOT** Included in Entire Record) ☐ Immunization records ☐ Medication list ☐ Physician progress/ visit notes	☐ Other: _____

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from the date below. I understand that only records available as of this date will be provided in response to this request. Should I need additional records in the future; a new request will be required.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization. (NOTE: HIPAA LAW ALLOWS 30 DAYS from receipt for processing.)

_____ _____

Printed Name of Patient or Legal Guardian / Representative Date

X _____

Signature of Patient or Legal Guardian/Representative

_____ _____

Relationship to Patient, if signed by Legal Guardian Witness Signature

Document(s) of patient representative's authority must be attached if patient is not signing.

To contact Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 /Suite 200/ Attn: Release of Information / Charleston, South Carolina 29425. The phone number is (843) 792-3881. Fax number is (843) 876-8080 or (843) 876-8055.