Beaufort Memorial HOSPITAL

955 Ribaut Rd., Beaufort, SC 29902

Authorization to Use or Disclose Protected Health Information

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

Patient Name_____ Date of Birth_____

Address (Street or P.O. Box, City, State, Zip Code)_____

Medical Record #_____ Account # _____ Telephone # _____

☐ I hereby authorize the following individual or organization

☐ Beaufort Memorial Hospital ☐ Other: _____

to release copies of my protected health information to: _____

(Name, Address, and Phone Number)

_____

☐ I hereby authorize Beaufort Memorial to obtain copies of my protected health information from: ***

_____

Treatment Dates _____ Purpose of Request _____

*** A copy of my identification will be made and attached to this authorization***

The following information is to be disclosed (please check):

☐ Discharge Summary ☐ History & Physical ☐ Office Notes ☐ Laboratory reports	☐ Radiology or imaging reports ☐ Emergency Department record ☐ Other _____ _____

For records released directly to the patient, there is a charge*.

Fees charged for copies of medical records are in accordance with S.C. Code Ann. § 44-7-325

Sensitive Information	I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.
Expiration	Unless otherwise revoked, this authorization will expire on the following date or when the following event or condition occurs: _____ _____ If I do not specify an expiration date, event, or condition, this authorization will expire in 180 days.
Redisclosure	I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR §164.524. If I have any questions about the disclosure of my health information, I can contact the Health Information Services Department at _____(telephone number).

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Patient _____

**** Staff Use Only****

***** Please send CD and reports to**: Women's Imaging Center, 989 Ribaut Rd., Suite 110, Beaufort, SC 29902

Telephone number: 843-522-5029 **Fax number**: 843-522-5848