



**CHARLESTON
ONCOLOGY**

COMPASSIONATE CARE FOR CANCER
AND BLOOD DISORDERS

Authorization for Use and Disclosure of Protected Health Information

Patient Name

Maiden or Previous Name

Date of Birth

Phone Number (Home)

(Work)

(Cell)

Authorize:		Release Records To:	
Charleston Oncology, P.A. Name of Physician/Healthcare Facility		_____ Name of Physician/Healthcare Facility	
2085 Henry Tecklenburg Dr, 2 nd Flr Street Address		_____ Street Address	
Charleston, SC 29414 City, State, Zip Code		_____ City, State, Zip Code	
(843) 576-1354 Telephone #	(843) 628-1083 Fax #	_____ Telephone #	_____ Fax #

Information to be released:

Date Range: From: _____ To: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab Results/Pathology Reports | <input type="checkbox"/> Letters |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> OB Records |
| <input type="checkbox"/> ER Reports | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Operation Reports |
| <input type="checkbox"/> Hospital Admission | <input type="checkbox"/> X-Ray Films/CD | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Hospital Observation | <input type="checkbox"/> Other: | |

Authorization for Use and Disclosure of Protected Health Information

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and by signing this form, I am specifically authorizing the release of information relating to:

- | | |
|---|--|
| <input type="checkbox"/> Substance Abuse (including alcohol/drug abuse) | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> HIV-related information (including AIDS related testing) | <input type="checkbox"/> Psychotherapy Notes |

The confidentiality of this record is required under W1 statute §252.12 and §252.15, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient or Legal Guardian	Date
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Reason for Disclosure:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Continued care by another provider | <input type="checkbox"/> Insurance Purposes | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Social Security Disability | <input type="checkbox"/> Attorney | <input type="checkbox"/> Other _____ |

If leaving Practice – Reason:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Dissatisfaction | <input type="checkbox"/> Moving | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Convenience of Hours | <input type="checkbox"/> Convenience of Location | <input type="checkbox"/> Other _____ |

I have read and understand the following:

- This authorization expires one year after I sign it or sooner (specify here: _____). This time period noted here may exceed one year only in certain situations specified by law.
- I may revoke this authorization at any time by notifying the facility in writing that I have authorized to release my records and this authorization will cease to be effective on the date notified. This will not apply to records that have already been released.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However other state or federal law may prohibit the recipient from disclosing specially protected information. Once the records are released, Charleston Oncology, cannot prevent them from being released to a third party.
- There may be a fee for releasing these records.
- To be valid, this authorization must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this authorization, my healthcare and payment for my healthcare will not be affected, and will not jeopardize my right to obtain future treatment, except where disclosure of the information is required for treatment.

Signature of patient or authorized person	Printed Name / Relationship to Patient (Parent, Guardian, Power of Attorney, etc.)	Date
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REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other

*****Photo ID is required to pick up records/films*****