



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____

City, State, Zip _____

Please list the names of any person authorized to receive medical information concerning the patient:

Initial each method you authorize the above person(s) to receive patient information:

- _____ Voicemail
- _____ E-mail
- _____ Phone conversation

Description of information to be released (Initial those that apply):

- _____ Date and time of my next appointment and with whom
- _____ Information results from any test or x-rays
- _____ Other information as described: _____

This authorization shall be in force and in effect until revoked by the patient or representative signing the authorization.

RIGHTS OF THE PATIENT

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED TO DISCLOSE AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Date