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 or Physician/Healthcare Facility
2085 Henry Tecklenburg Dr, 2nd Flr Street Address	_____ Street Address
Charleston, SC 29414 City, State, Zip Code	_____ City, State, Zip Code
(843) 576-1354 (843) 628-1083 Telephone # Fax #	_____ Telephone # Fax #
	_____ Email

Date Range: From: _____ To: _____

Information to be released:

- ☐ Progress Notes
- ☐ Physical Therapy
- ☐ ER Reports
- ☐ Hospital Admission
- ☐ Hospital Observation
- ☐ Lab Results/Pathology Reports
- ☐ Discharge Summaries
- ☐ X-Ray Reports
- ☐ X-Ray Films/CD
- ☐ Other: _____
- ☐ Letters
- ☐ OB Records
- ☐ Operation Reports
- ☐ Consultations

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:

☐ Substance Abuse (including alcohol/drug abuse) ☐ Mental Health

☐ HIV-related information (including AIDS related testing) ☐ 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

Reason for Disclosure:

☐ Continued care by another provider ☐ Insurance Purposes ☐ Personal Use

☐ Social Security Disability ☐ Attorney ☐ Other_____

If leaving Practice – Reason:

☐ Dissatisfaction ☐ Moving ☐ Insurance

☐ Convenience of Hours ☐ Convenience of Location ☐ 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

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other

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