

## **MEDICAL RECORDS**

Lexington Medical Center

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A Lexington Medical Center Physician Practice

## Authorization for Release of Protected Health Information

Patient's full name at the time of treatment:						
Date of Birth: / /	/         Social Security Number:					
Date(s) of treatment:						
Purpose of release:						
I authorize the following provider/entity Recipient/Provider Name: Recipient's Address:						
City:						
🗆 Portal 🛛 Mail Record 🗌 Pick-up	□ FAX (to health provider only)	I request a copy of this authorization				
Information To Be Released: (Please check all that apply)						
<ul> <li>Bill</li> <li>Cytology Reports</li> <li>Diagnosis List/Patient Identification</li> <li>Emergency Department Records</li> <li>EKG/Cardiovascular</li> <li>Laboratory Report (type)</li> <li>Mammography Films</li> <li>Occupational Therapy Reports</li> <li>Office Notes (type)</li> </ul>	Pulmonary Funct Radiology Film (t Radiology Repor Radiology Repor Speech Therapy Other:	/ Reports on (type) tion Test type) ts				

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.

2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.

6. I understand that a copy or FAX of this document is just as valid as the original document.

7. I understand that this authorization will expire 90 days after signed unless an earlier date is specified here \_

	Signature of Patient or Authorized Person		Date	Contact Telephone Number
	Relationship	Reason Patient is Unable to Sign		
PROVIDER	Original to Medical Records:	/ Date	/ Copy to:	/ / Date
USE ONLY	Verification Completed By:			