Upstate Lung and Critical Care Specialists

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ DOB: ________________________
Last 4 of SS: ____________ Phone Number: ____________________________________
Address: _________________________________City_____________State:_______Zip:_________

Important: Every section of this form must be **COMPLETED** to be considered valid. There may be fees associated for copies of medical records/images and postage fees as provided by S.C. Law.

Release Records to or from (**Who** may have this information? **Where** do you want information sent?)	Individual OR Organization: ______________________ Attn to: ______________________ Address:______________________ City:_______________State:__________Zip:__________ Phone: _______________Fax:_______________ Email: ______________________
Release Instructions (**How** do you want to the information released?)	**Release Method/Format Request: (Check One)** ○ Mail ○ Fax (For healthcare providers/organizations as permitted) ○ In Person ○ Encrypted Email to this address:____________________ ○ Other (Specify)____________________ Important: I understand that undecrypted emails are not secure- that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted email including mis addressed/misdirected; e-mails accounts that are shared; messages forwarded to others; and messages stored on portable devices having little secuirty. By choosing to receive My Health information on an Undecrypted e-mail, I'm acknowledging and accepting these risks. I understand there may be a fee for a copy of my health information. And understand that all fess will be compliance with applicable laws. I agree to pay this fee.
Purpose of Release (**Why** is it needed?)	☐ Continuing Care ☐ Disability ☐ Other, specify __________ ☐ Legal ☐ School ____________________ ☐ Patient Request ☐ Military ____________________

☐ History & Physical
☐ Progress Notes
☐ Operative Notes
☐ Laboratory Reports
☐ Radiology Reports
☐ Emergency Reports
☐ Other

Information to be released: **What** do you want sent or released? Check the appropriate box.	☐ Entire Medical Record ☐ Abstract of Medical Records- History & Physical, consults, labs & radiology reports, discharge summary.	○ Medication List ○ Progress Notes/visit notes ○ Billing Statements ○ Other: ____________________
Treatment Date(s) and Location (select **when** you were seen)	○ Treatment dates from ________________to ____________________ ○ All treatment dates	

I understand this information may include reference to psychiatric/psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV/AIDS and or alcohol abuse.
I understand that I have a right to cancel /revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to the Health Information Services Department known as Medical Records . I understand that the cancellation/revocation will not apply to information that has already been released in response to this authorization, as state in the Notice of Privacy Practice. Unless otherwise cancelled /revoked, this authorization will expire/end one year from the date below. I understand that only records available as of this date will be provided in response to this request. Should I need additional records in the future; a new request will be required. I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review the information to be disclosed, as provided in 45 CFR$164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person /organization receiving the information. I understand I will be given a copy of this authorization.

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

(NOTE: HIPAA LAW ALLOWS 30 DAYS from receipt for processing)

Print Name of Patient or Legal Guardian/Representative

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Date:______________________________

Signature of Patient or Legal Guardian/Representative

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Relationship to Patient, if signed by Legal Guardian

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Witness Signature

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