UPSTATE LUNG
& CRITICAL CARE SPECIALISTS

151 Harold Fleming Court Spartanburg, SC 29303
1529 N Limestone Street-B Gaffney, SC 29340
1005 Thompson Blvd.-A Union SC 29379
Main Fax: 864-573-6323

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
☐ Legal
☐ Patient Request
☐ Disability
☐ School
☐ Military
☐ Other, specify _____
_____
_____

☐ History & Physicial
☐ 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 & Physicial, 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

Date:_____

_____

Signature of Patient or Legal Guardian/Representative

_____

Relationship to Patient, if signed by Legal Guardian

_____

Witness Signature

_____

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