Beaufort Memorial HOSPITAL

AUTHORIZATION TO RELEASE OR REQUEST HEALTH INFORMATION

Patient Name_____ Date of Birth _____

Medical Record # _____ Last 4 digits Social Security Number _____

☐ I hereby authorize the Custodian of Medical Records at Beaufort Memorial Hospital to release to:
☐ I hereby authorize Beaufort Memorial Hospital to obtain Medical Records from:

Name of Individual/ Organization: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone #: _____ Fax #: _____

The purpose of the disclosure is: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request

☐ Other:_____ Date(s) of Service: _____

☐ An **"abstract"** of the medical record is provided as the first level of release of information (comprehensive overview of entire record). This includes: history and physical, consults, lab and radiology reports, discharge summary, operative / procedure reports, Emergency Department reports, Occupational Therapy / Physical Therapy reports.

In addition to the "abstract" information, the following information may be requested:

☐ Films / images	☐ Immunization records	☐ Medication list	☐ Physician progress / visit notes
☐ Physician orders	☐ Nurses notes	☐ Entire record	☐ Other:

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 authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I do not need to sign this form to receive treatment. I understand I may review and / or copy 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.

I understand that I may revoke this authorization at any time by notifying in writing the person/ organization providing the information. However the revocation will not be valid if:

(a) Action has already been taken in response to this authorization; or
(b) If this authorization is obtained as a condition for obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization will expire on the following date or event _____
If I do not specify an expiration date or event, this authorization will expire 180 days from the date on which it was signed.

I understand that fees for copies of medical records and postage fees may be charged.

Signature: _____ _____
Patient or Legal Representative/ Date Relationship

_____
Witness/ Date

We are required by law to respond to this request within 30 days of its receipt.