



Beaufort Memorial HOSPITAL

RELEASE OR REQUEST OF PATIENT HEALTH INFORMATION 1 of 2

Patient Name _____ Unit (MR) / Account # _____
 Date of Birth _____ Telephone # (____) _____
 Address _____ City, State, Zip Code _____

I hereby authorize the Custodian of Health Information at Beaufort Memorial Hospital to:

RELEASE TO:

OBTAIN FROM:

Person/Facility Agency _____
 Address _____
 City, State, Zip _____
 Telephone # _____

Specific description of information that may be used/ disclosed:

- | | | |
|---|--|--------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Inpatient | Dates of Treatment _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Outpatient | Dates of Treatment _____ |
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Emergency Room | Dates of Treatment _____ |
| <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Radiology Report(s) | |
| <input type="checkbox"/> Please provide complete medical records <input type="checkbox"/> Other _____ | | |

This information will be used/ disclosed for the following purpose:

- Continuing Care Personal Legal Other _____

I authorize Beaufort Memorial Hospital to release sensitive information as indicated:

- AIDS/ HIV Drug/ Alcohol Abuse Sexually transmitted disease Mental/Behavioral Health

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 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 redisclosed 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.

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.



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RELEASE OR REQUEST OF PATIENT HEALTH INFORMATION 2 of 2

NOTE: *There will be a charge for a personal copy or the permanent transfer of your records. You will be invoiced directly if our copying service completes the request.*

MEDICAL INFORMATION RELEASED

Entire Chart Lab _____
DS _____ EKG _____
OP _____ X-Ray _____
H&P _____ Path _____ Other _____
Number of Pages _____

Release of Information Specialist

Date

Created: 03/08/06

Revised: 03/28/06; 03/28/10; 04/30/10