LEXINGTON MEDICAL CENTER

MEDICAL RECORDS

2720 Sunset Blvd., West Columbia SC 29169 • (803) 791-2264 • FAX: (803) 791-2136

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 _____ to release my health information to:

Recipient/Provider Name: _____

Recipient's Address: _____

City: _____ State: _____ ZIP: _____

☐ Mail Record ☐ I will pick-up ☐ FAX (to health provider or health plan only) ☐ I request a copy of this authorization

Information To Be Released: (Please check all that apply)

☐ Bill
☐ Cytology Reports
☐ Diagnosis List/Patient Identification
☐ Emergency Department Records
☐ EKG/Cardiovascular
☐ Laboratory Report (type) _____
☐ Mammography Films
☐ Occupational Therapy Reports
☐ Office Notes (type) _____
☐ Pathology Reports
☐ Physical Therapy Reports
☐ Physician Dictation (type) _____
☐ Pulmonary Function Test
☐ Radiology Film (type)_____
☐ Radiology Reports
☐ Speech Therapy Reports
☐ Other: _____
_____

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 USE ONLY

Original to Medical Records:_____ / _____ / _____ Copy to: _____ / _____ / _____
Date Date

Verification Completed By:_____