PALMETTO HEALTH

***Retain Original and Provide Patient with A Photocopy** **MR# / SSN: _____**

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Hereby Authorize Palmetto Health to Use or Disclose my Protected Health Information as Described Below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____
First Middle Last

Address: _____ Telephone Number: _____

Social Security Number: _____ Date of Birth: _____

Name of Person/facility Authorized to **RELEASE** the information: _____

Name of Person/facility Authorized to **RECEIVE** the Information: _____

Address: _____ Telephone Number: _____

City, State, and Zip Code: _____ Fax Number: _____

Purpose of Disclosure: _____

Dates of Treatment: _____

Information to be Used/Disclosed – Please check those that apply:

History and Physical __	Discharge Summary __	Operative Report __	Other (specify) _____
Progress Notes __	Laboratory Report __	Radiology Report __	Immunization Record __
Billing Summary __	Consultation Report __	Pathology Report __	Entire Medical Record __

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

Palmetto Health may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. **The facility has already acted on your request prior to receiving the request to cancel the authorization; or**
2. **If the authorization was given to release records to your insurance company in order to obtain insurance coverage.**

This authorization will automatically expire in 90 days unless otherwise stated.

Expiration Date: _____

_____ _____
Signature of Patient or Legally Qualified Representative Date

_____
Relationship of Legally Qualified Representative

Please Address Correspondence to the Appropriate Address:

Palmetto Health Richland
Insert Respective Department Name Here
Five Richland Medical Park
Columbia, SC 29203

Palmetto Health Baptist
Insert Respective Department Name Here
Taylor at Marion Street
Columbia, SC 29220

Palmetto Health Baptist Easley
Insert Respective Department Name Here
P.O. Box 2129
Easley, SC 29641