AUTHORIZATION TO RELEASE/OBTAIN PATIENT-IDENTIFIABLE HEALTH INFORMATION
PHONE #: (803) 276-7570
FAX #: (803) 276-8518

Patient Name: _____ **Medical Record #:**

SSN#: _____ DOB: _____

I authorize the use or disclosure of the above named individual's health information as described below:

☐ **Newberry County Memorial Hospital** ***OR*** ☐ **Other:** _____
(2669 Kinard Street, Newberry, SC 29108)

To disclose to: _____ _____
Name/Facility Address

_____ _____ _____
City State Zip Code Fax # (_____) _____ - _____

The following health information may be released (check all that apply), specify dates of treatment:_____

☐ Discharge Summary ☐ History/Physical Examination ☐ Emergency Room Record ☐ Laboratory Results
☐ Consultation Reports ☐ X-ray / Imaging Report ☐ Physician's Order's ☐ Psychotherapy Notes
☐ Operative Reports ☐ Pathology Reports ☐ Entire Record
☐ Other Information: _____

FILMS ***(pick up in radiology or appropriate department)***

☐ EKG Tracings ☐ Holter Monitor ☐ Stress Test Tracing ☐ ECHO ☐ CAT Scan Film
☐ X-Ray Film ☐ Ultrasound Film ☐ Nuclear Medicine Film ☐ DEXA Scan ☐ MRI Film

The information will be obtained, used, or disclosed for the following purpose(s) only (check all that apply):

☐ Insurance ☐ Personal Use ☐ Continued treatment ☐ Social Security/Disability
☐ Attorney/Legal ☐ At the request of the patient or patient's representative ☐ Other (specify)_____

I understand that I have a right to revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to the NCMH Medical Records Department. I also understand that the withdrawal will not apply to businesses that use the information for treatment, payment, or operations associated with my personal health care (ex. Health Insurance Company). Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months and no further use of the patient's confidential healthcare information is permitted beyond that day.

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, NCMH will not condition the provision of treatment or payment on obtaining an authorization to release information.
- The patient will receive a copy of the signed authorization.

I understand that the information in my health record may include information relating to sexually transmitted disease, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Signature of Witness

_____ Identity of the requestor has been verified **(to be initialed by a NCMH employee).**