



**Family Physicians of Spartanburg
Authorization for Use and Disclosure of Protected Health Information**

Patient Identification

Printed Name: _____
Address: _____

Date of Birth: ____/____/____
Social Security #: ____-____-____
Telephone: (____) ____-____

Information to be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check the type of information to be released:

- | | | |
|--|--|--|
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Pathology report | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Consultation report | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Laboratory test results/reports | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Itemized bill |
| <input type="checkbox"/> Operative report | <input type="checkbox"/> Emergency room record | <input type="checkbox"/> Other _____ |

Purpose of Request

- | | | |
|--|--|--|
| <input type="checkbox"/> Treatment or consultation | <input type="checkbox"/> At the request of the patient | <input type="checkbox"/> Billing or claims payment |
| <input type="checkbox"/> Other _____ | | |

***** Notice: In some cases, the copying of medical records is processed by an outside company that charges a fee for service. Therefore, it is the patient's responsibility to compensate these costs. The copy service will mail a statement to patient in the event that services are charged. If the charges are not compensated, the records will not be released to the receiving practice. _____ Initials**

Release information from this practice:

To this practice:

**Family Physicians of Spartanburg
3021 Reidville Road
Spartanburg, SC 29301
Ph: (864) 576-9201 Fax: (864) 576-6584**

Person Authorized to Receive Information:

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to this release.

Check one: Yes No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to this release.

Check one: Yes No _____ Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the practice. Unless revoked, this authorization will expire on the following date or event _____ . If no expiration date is set forth, this authorization will expire 180 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that the practice may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Family Physicians of Spartanburg to use and disclose the protected health information specified above.**

Signature: _____

Date: _____

Authority to Sign if not patient: _____

Identity of requestor verified via: (Circle one) Photo ID Matching Signature Other _____

Verified by: _____