

AUTHORIZATION FOR RELEASE OF INFORMATION

Spartanburg & Pelham OB-GYN
250 North Grove Medical Park Drive
Spartanburg, SC 29303
864-208-2345

Patient Name: _____ Date of Birth _____

Address: _____

City/State/Zip: _____ Telephone _____

I authorize the release of medical information as indicated below:

From: Spartanburg & Pelham OB-GYN To:

- I would like to pick up my records: Please call me at _____
 I would like records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

- | | |
|--|--|
| <input type="checkbox"/> Outpatient notes | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> X-Ray report(s) | <input type="checkbox"/> X-ray Film(s) |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Other Specify _____ | <input type="checkbox"/> All medical records |
| | <input type="checkbox"/> Billing records |

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

- | | | |
|--|------------------------------|--------------------------------|
| The diagnosis or treatment of AIDS, including results of HIV tests | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| The diagnosis or treatment of drug and/or alcohol abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| The treatment and/or consultation for mental health or psychiatric disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| Psychotherapy notes | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |

Purpose of the release: Please indicate the reason for this release

- | | |
|---|---|
| <input type="checkbox"/> For another doctor | <input type="checkbox"/> To obtain disability |
| <input type="checkbox"/> Use in a lawsuit | <input type="checkbox"/> Worker's care |
| <input type="checkbox"/> Follow-up related to an injury | <input type="checkbox"/> Armed forces requirement |
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Other _____ |

Format of the release:

- Hardcopy
 Fax
 Email

I understand that electronic media, and delivery methods such as unencrypted email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of Spartanburg & Pelham OB-GYN. I agree to assume such risks personally, and to hold Spartanburg & Pelham OB-GYN harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing Spartanburg & Pelham OB-GYN to transmit or deliver such information electronically.

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

Please change the expiration date to last for _____ days.

I understand this Authorization can be revoked at any time according the Spartanburg & Pelham OB-GYN privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Spartanburg & Pelham OB-GYN and may potentially be re-disclosed by the party who received these records. Spartanburg & Pelham OB-GYN, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Disability Forms/ FMLA Forms

- I acknowledge that I have been informed that it takes up to 10 business days to complete the forms.
- I understand that I will be contacted as soon as the forms are completed. If you have not been contacted after 14 days, please contact our office.
- I have also been informed that I will be charged a fee of \$20 for the 1st form and \$10 for each additional form.

Signature of Patient	Date

Signature of Legal Representative	Date

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FOR OFFICE USE ONLY

Received by:			
Date Received:		Time Received:	
Action(s) Taken:			
PHI Disclosed To:			
Disclosure Media:	<input type="checkbox"/> Hardcopy <input type="checkbox"/> Email <input type="checkbox"/> Other (describe)		
FMLA Payment:	_____ \$20 Paid _____ \$10 Paid _____ Pay at Pick-up		
Discloser's Signature:			