MEDICAL RECORDS RELEASE FORM

(AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION)

PATIENT NAME: _____DATE OF BIRTH: _____SOCIAL SECURITY #: _____

★ I AUTHORIZE **TRIDENT PAIN CENTER** TO *(CHOOSE ONE)*

☐ DISCLOSE/RELEASE INFORMATION TO: ☐ OBTAIN INFORMATION FROM:

NAME OF ORGANIZATION OR ENTITY: _____PHONE #: _____

ADDRESS: _____

_____

★ THE **PURPOSE** OF THE DISCLOSURE IS: _____

★ I AUTHORIZE THE FOLLOWING **TYPE(S) OF INFORMATION** TO BE DISCLOSED:

FOR DATES OF SERVICE: _____ THRU _____

☐ OFFICE/PROCEDURE NOTE(S) *(INCLUDE BUT ARE NOT LIMITED TO HISTORY, PHYSICAL EXAM, ALLERGIES, MEDICATIONS)*
☐ DIAGNOSTIC IMAGING REPORTS *(WILL ONLY RELEASE IF ORDERED BY A PROVIDER OF TRIDENT PAIN CENTER)*

☐ PATIENT INFORMATION FORM(S)	☐ LAB DOCUMENTS/REPORTS
☐ CONSULT NOTES	☐ REFERRAL NOTES
☐ CONSENT(S) FOR PROCEDURE	☐ NEW PATIENT PAPERWORK
☐ PRESCRIPTION(S)	☐ MEDICAL RECORDS RELEASE(S)
☐ LETTER(S) TO/FROM PATIENT	☐ AUTHORIZATION CORRESPONDENCE
☐ LETTER(S) TO/FROM PHYSICIANS	☐ LETTER(S) TO/FROM ATTORNEYS

★ I AUTHORIZE THE **EXCHANGE** OF THIS INFORMATION VIA: ☐ CERTIFIED MAIL ☐ FAX ☐ OTHER_____

★ **READ CAREFULLY AND INITIAL** EACH OF THE FOLLOWING STATEMENTS:

_____I UNDERSTAND THAT I HAVE A **RIGHT TO CANCEL/REVOKE THIS AUTHORIZATION** AT ANY TIME. I UNDERSTAND THAT IF I CANCEL/REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN CANCELLATION/REVOCATION TO THE HEALTH INFORMATION SERVICES DEPARTMENT (MEDICAL RECORDS). I UNDERSTAND THAT THE CANCELLATION/REVOCATION WILL NOT APPLY TO INFORMATION WHICH HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION AS STATED IN THE NOTICE OF PRIVACY PRACTICE. UNLESS OTHERWISE CANCELLED OR REVOKED THIS AUTHORIZATION WILL EXPIRE/END 90 DAYS FROM THIS DATE.

_____I UNDERSTAND THAT A **REASONABLE, COST BASED FEE** FOR COPIES OF PROTECTED HEALTH INFORMATION AND POSTAGE FEES WILL BE CHARGED.

_____I UNDERSTAND THAT **AUTHORIZING THE DISCLOSURE OF PROTECTED HEALTH INFORMATION IS VOLUNTARY**. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I DO NOT NEED TO SIGN THIS FORM TO RECEIVE TREATMENT. I UNDERSTAND I MAY REVIEW AND/OR COPY THE INFORMATION TO BE DISCLOSED, AS PROVIDED IN CFR 164.524. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POSSIBILITY OF UNAUTHORIZED DISCLOSURE BY THE PERSON/ORGANIZATION RECEIVING THE INFORMATION. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OR USE OF MY PROTECTED HEALTH INFORMATION I MAY CONTACT THE MEDICAL RECORDS DEPARTMENT (843) 797-3636 EXT. 203.

_____I UNDERSTAND I WILL BE GIVEN A **COPY OF THIS AUTHORIZATION UPON REQUEST.**

_____I UNDERSTAND THAT IF THIS INFORMATION IS REQUESTED IN PERSON I WILL BE ASKED TO **PROVIDE PICTURE IDENTIFICATION** (E.G. DRIVER'S LICENSE). A COPY OF MY IDENTIFICATION WILL BE MADE AND ATTACHED TO THIS AUTHORIZATION.

★ SIGNATURES:

PATIENT: _____
SIGNATURE PRINTED NAME DATE

*FOR SIGNATURE OF **LEGAL GUARDIAN/REPRESENTATIVE** TO BE CONSIDERED VALID, THE FOLLOWING MUST BE PROVIDED:

RELATIONSHIP TO PATIENT _____

DESCRIPTION OF AUTHORITY (REASON PATIENT IS NOT SIGNING) _____

WITNESS: _____
SIGNATURE PRINTED NAME DATE

TO CONTACT HEALTH INFORMATION SERVICES (MEDICAL RECORDS) IN WRITING THE ADDRESS IS:
TRIDENT PAIN CENTER
9267 MEDICAL PLAZA DRIVE, SUITE G
NORTH CHARLESTON, SC 29406
ATTN: MEDICAL RECORDS DEPARTMENT