AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TIDELANDS HEALTH

I hereby authorize: *(Check One)*

_____ Tidelands Georgetown Memorial Hospital
606 Black River Road, 29440-3304
Georgetown, South Carolina
Phone: 843-520-8404; Fax: 843-520-8073

_____Tidelands Waccamaw Community Hospital
4070 Highway 17 Bypass, 29576-5033
Murrells Inlet, South Carolina
Phone: 843-652-1098; Fax: 843-652-1085

To release the following information from the health records for:

1 . **Patient's** Name**:**_____ **Patient's** Date of Birth**:**_____

Patient's Social Security Number(Last 4 digits)**: XXX-XX- _ _ _ _** **Patient's** Telephone**:**_____

2. **Covering The Periods of Treatment: From:**_____ **To:**_____

3. **Information To Be Released As Checked:**

_____ Abstract *(discharge summary, consultation reports, emergency department reports, history & physical, laboratory reports, operative reports, pathology reports, x-ray reports)*
_____ Consultation Report
_____ Discharge Summary
_____ Emergency Department
_____ Other ***[Please Specify]:***_____

_____ History & Physical
_____ Laboratory Report
____ Operative Report
____ Pathology Reports
____ X-ray Reports
____ Cardiac Studies

_____ Complete Record
_____ Medication Admin. Records
____ Nurses Notes
____ Other Diagnostic Reports
____ Progress Notes
____ X-Ray Films/CD

4. *Type of Access Requested:* _____*Copy of the record/s* _____*Inspection of the record/s*

5. _____ I understand that this information may include references to or treatment of drug or alcohol abuse, psychological illness, or test results for HIV/AIDS.
Initials

6. **Information Is To Be Released To**: Name:_____

Address:_____City:_____State:_____Zip:_____

Telephone Number:_____Fax Number:_____

7. Purpose of Disclosure: _____Continued Health Care ____Personal Reasons ____Insurance ____Legal ____Other

8**.** **This Authorization expires six {6} months from the date signed below and covers only treatment for the dates specified.**

9. *I understand that this authorization may be withdrawn by me at any time as explained in the Tidelands Health Notice of Privacy Practices except to the extent that action has been taken in reliance upon it. I understand that information disclosed under this authorization may be re-disclosed by the recipient of the information and the information may not be given the same protection it receives from the hospital. The facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "**Authorization for Release of Medical Information**." I understand that I have the right to refuse to sign this authorization and the Hospital may not condition treatment based upon my refusal to sign the authorization unless the authorization is necessary for research related treatment of healthcare related services provided solely for the purposes of releasing the information to a 3rd party.*

10. A photo static copy of this authorization is to be considered as valid as the original.

11. Fees/charges will comply with all laws and regulations applicable to release of information.

12**.** ***I understand that the Hospital has up to thirty [30]days to provide access to my record for records stored on-site, and up to sixty [60] days to provide access to records stored off-site.***

Signature of Patient or Guardian:_____Date:_____

Patient/Guardian/Requester Picture ID [Copy]:_____Guardian's Relation to Patient:_____
Documentation of Healthcare Power of Attorney for adult patient or emancipated minor [copy attached]_____

Processed by:_____/_____Date_____
Print name of Processing Staff Signature of processing staff