SPARTANBURG
Regional Healthcare System

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	**NAME:**_____ **DATE OF BIRTH:**_____ **Address:** _____**City:** _____**State** _____ **Zip:** _____ **Daytime Phone: (_____)**_____ **SS#:** _____-_____-_____
Hospital/Health Care Provider (**From** which provider - SRMC, VH, Rehab, Physician, Other)	**Facility/Provider Name:** _____ **Address:** _____**City:** _____**State** _____ **Zip:** _____ **Phone: (_____)**_____ **Fax: (_____)**_____
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	**NAME:** _____**Attention to:** _____ **Address:** _____**City:** _____**State** _____ **Zip:** _____ **E-Mail Address (ELECTRONIC REQUESTS ONLY):** _____ **Fax Number (URGENT PATIENT CARE ONLY):** _____
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	**Dates of Service from** _____ **to** _____**.** ☐ **Routine Record Sets** Provider (office visit, diagnostic test results, problem list, medication list/allergies, immunizations) Hospital (History/Physical, Discharge Summary, Op Report, Consultations, Emergency, diagnostic test results) ☐ **Copies of Films/Images** ☐ **Any and all records** ☐ **Other Records:** specify record type(s) _____ This authorization places no restriction on any information to be released, including any treatment for alcohol, drug abuse, HIV testing, or psychiatry. If restrictions are to be placed on information released, please state: _____
Release Instructions (***How do*** you want the information?)	**Release Method requested: (check one):** ☐ **Paper** ☐ CD ☐ **Electronic*** ☐ **View my Record** ☐ **Fax (patient care only)** ***Electronic requests will be provided as an Adobe PDF file on HealthPort's eDelivery website. Recipient will receive an e-mail from HealthPort.com containing instructions for accessing the file. If the recipient does not retrieve the file within 30 days, it will be deleted.**
Purpose of Release (***Why*** is it needed?)	☐ **Continuing care** ☐ **Transfer of care** ☐ **Social security appeal** ☐ **Insurance application** ☐ **Personal use or review** ☐ **Insurance payment/claim** ☐ **Litigation/legal** ☐ **Social Security Disability determination** ☐ **Other** _____ **Fees will be charged in accordance with SC Code and Federal Rule 45 C.F. R. §164.524.**

- This authorization is valid for one year after the date signed unless you enter a different date here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- SRHS Hospitals & Providers will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- SRHS's records may include records received from other organizations. If these records have been used by SRHS and filed in the record SRHS maintains about you, these records may be released with your SRHS records.
- SRHS cannot prevent re-disclosure of your information by recipient of your records under this authorization. By signing this authorization, you release SRHS from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Signature of Patient / Legal Representative Date/Time Authority to act on behalf of patient (attach document)

Witness Date/Time

For office use only:

Patient ID Type/Number:_____

Encounter/MR #:_____

Processed By:_____

Date/Time:_____

Patient Label