Authorization to Receive Protected Health Information

Date:_____

To:_____ Tel:_____

_____ Fax:_____

_____
(We must have a complete address or the release form may not be sent)

I, _____, authorize MBFM to receive my protected health information. I have read this authorization and understand what information will be used or disclosed and the recipient who may use and disclose the information. Release medical records to:

Myrtle Beach Family Medicine, PA
831 82nd Parkway,
Myrtle Beach, SC 29572
Tel: (843) 449-5243 Fax: (843) 449-2333

1.[ ] The patient's entire medical record **without limitation**.
2.[ ] The patient's entire medical record **with limitation** **(Do not include)**: [] HIV/AIDS [] Mental Health [] Substance Abuse
3.[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____
4.[ ] Other: _____

Purpose of this authorization: []treatment []_____

This authorization shall expire on [ ] after 1 disclosure [ ] 1 year, [ ] no expiration.
[ ] (list specific date)_____

Sensitive Information: I understand that my record may include information relating to AIDS or HIV, psychiatric, psychological, behavioral or mental health diagnoses or treatment, sexually transmitted diseases, alcohol and/or drug abuse and this information will be requested by this released if not limited by above requests options.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may NOT be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already received by this released.
Expiration: I understand this authorization will expire as listed above.
Charges: I understand if there is a charge for these requested records, the patient will be responsible for these costs as outlined in Section 44-115-80 Physician's Patient Record Act.

_____ _____
Patient's Signature Date Witness

Print Patient Name: First_____MI_____Last_____

Date of Birth_____ Social Security Number_____

FOR OFFICE USE ONLY Revised 2/14/05
Date Authorization sent_____.