**Myrtle Beach Family Medicine, PA**
**831 82nd Parkway, Myrtle Beach, SC 29572**
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# Authorization by Patient for MBFM to Use/Disclose Protected Health Information
## (Authorization for MBFM to Release Information)

**Patient name:_____DOB:_____SS#_____**

I understand MBFM is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of MBFM, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's entire medical record (**without limitation** for AIDS/HIV, Mental Health, Substance Abuse) for treatment rendered at MBFM only.
[] For all dates of service
[] For these dates of service (specify)_____

[ ] The patient's entire medical record (**with limitation)**-**Do not include:**
[]AIDS/HIV []Mental Health []Substance Abuse

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____

Purpose of this authorization: [ ] Moving [ ] Changing Doctor
[ ] Specialist Review [ ] Insurance Review [ ] Self Review [ ] _____

**I authorize my protected health information be sent to:**

**Person's Name:_____**

**Company Name:_____**

**Mailing Address:_____**

**City _____ State_____ Zip_____**

**Telephone:_____ Fax:_____**

The patient understands that MBFM may receive financial gain as a result of disclosing this information .

This authorization permits MBFM to send the protected health information ONLY to the address on this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, MBFM must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

MBFM will accept written revocations of this authorization via:

- In Person
- Certified US Mail

ALL revocations must be sent to MBFM to the attention of the Office Manager or Privacy Officer of MBFM, and are not effective until received by the Office Manager or Privacy Officer.

This authorization shall expire on [ ] _____ [ ] 30 days, [ ] 60 days, [ ] 90 days, [ ] 1 year, [ ] no expiration. After this date, MBFM can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

All records will incur a charge. Section 44-115-80 Physician's Patient Records Act:
A physician may charge a fee for the search and duplication of a medical record, .65 cents per page the first thirty pages, .50 cents per page for all other pages, and a administration fee of $15.00 per request plus actual postage.

I fully understand and accept the terms of this authorization.

Patient signature_____ Date:_____

SS#_____ Witness:_____

Date of Birth_____

FOR OFFICE USE ONLY Revised 2/14/05

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.