ReGenesis Health Care

My Family. My Doctor. My Choice.

Release of Information Authorization

Address: PO Box 5158, Spartanburg, SC 29304

Phone: (864) 582-2411 Fax: (864) 582-7178

Patient Name: _____ Guardian Name: _____

Date of Birth: _____ Last 4 Digits of SSN: _____ Phone #: _____

NOTE: All items including 1 through 6 and initialing paragraphs must be completed, along with signature and date

1.) Release Records To: (**Where** do you want the information sent? **Who** may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____
2.) Obtain Records From: (**Who** has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____
3.) Release Instructions: (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Mail ☐ Fax (To healthcare provider ONLY) ☐ Pick up in person at: ☐ Langdon ☐ 750 Church ☐ Woodruff ☐ Northside ☐ Park Hills ☐ Gaffney ☐ Union
4.) Purpose of Release: (**Why** is it needed?)	☐ Continuing Care ☐ Transfer of Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ Disability ☐ School ☐ Other: _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by SC Law.
5.) Treatment Date(s): (**When** were you seen?)	☐ Treatment dates from _____ to _____ (please be specific) **OR** ☐ All Treatment Dates
6.) Information to be Released: (**What** do you want sent or released? Check the appropriate box)	☐ All medical information including: History & Physical, Consults, Lab & Radiology Reports, Operative/ Procedure Reports ☐ Behavioral Health/ Counseling ☐ Dental ☐ Demographics ☐ Test Results ☐ Immunization Records ☐ Physician Progress / Visit Notes ☐ Other: _____

Please initial all three paragraphs that you understand your rights regarding what information will/could be disclosed:

_____ **I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS. This information may have been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. This prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted in written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 160 & 164. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

_____ 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 ReGenesis Health Care. I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization. This authorization will expire / end one year from the date of signature unless otherwise specified.

_____ 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 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.

Proof of identity may be required. (NOTE: Allow up to 30 days for processing according to Federal regulation.)

Be aware the processing of this document will release the entire medical record requested which may include information from other providers.

_____ _____

Printed Name of Patient or Legal Guardian/Representative Date

_____ _____

Signature of Patient or Legal Guardian/Representative Relationship to Patient, if Signed by Legal Guardian

Office Use Only

Printed Name of Witness: _____ Record Copy Fee Paid: _____

Signature of Witness: _____ Date/Time Witnessed: _____