LOVELACE FAMILY MEDICINE, PA

Authorization **Request for** Disclose Health Information

Patient Name: _____ **PHONE #** _____
Date of Birth: _____ **Chart Number:** _____
Patient Address: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Requesting From: _____
   Address: _____
   _____
3. **What would you like to do with the records after they have been reviewed?**
   - ☐ Return to patient
   - ☐ Permission to shred
4. **The type and amount of information to be used or disclosed is as follows:**
   - ☐ Entire record
   - ☐ Other (please include date range): _____
     _____
     _____
     _____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

6. This information may be disclosed to and used by the following individual or organization:
   Name: Lovelace Family Medicine, PA **Phone:** 803-364-4852
   Address: PO Box 630, 600 N. Wheeler Avenue **Fax:** 803-364-2014
   Prosperity, SC 29127
   Purpose of Release:
   - ☐ Medical Care ☐ Legal representation
   - ☐ Other: _____

7. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness

_____
Description of Representative's Authority (attach any necessary documentation)

Revised 10/26/18