RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____

Last First Middle

Home Address:_____

_____

Home Telephone:_____ **Date of Birth**: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report

☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report

☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record

☐ Other_____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom Southern Surgery Specialists may disclose my health information: _____

Address of the recipient or where my health information should be delivered:_____

_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20____.

☐ Until Southern Surgery Specialists fulfills this request.

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE: I authorize Southern Surgery Specialists to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] _____

RECORD RELEASE/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Southern Surgery Specialists discloses my health information to the recipient, Southern Surgery Specialists cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Southern Surgery Specialists may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment Southern Surgery Specialists; except, however, if my treatment at Southern Surgery Specialists is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Southern Surgery Specialists may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation Southern Surgery Specialists Privacy Office at the address listed below. The revocation will be effective immediately upon Southern Surgery Specialists receipt of my written notice, except that the revocation will not have any effect on any action taken by Southern Surgery Specialists in reliance on this Authorization before it received my written notice of revocation.

I may contact Southern Surgery Specialists **Privacy Office by e-mail at HHH-Privacy@TenetHealth.com.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Southern Surgery Specialists **to use or disclose my health information in the manner described above.**

Signature of Patient	**Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Personal Representative	Relationship to Patient	Date

Southern Surgery Specialists
Medical Plaza, 1010 Medical Center Dr., Suite 250, Hardeeville, SC 29927
Phone: 843-682-2519Fax: 843-943-4347

408 Jackson Ave., East Hampton, SC 29924
Phone: 843-943-4003 Fax: 843-943-4347