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AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

Patient's Name (please print): ____

Date of Birth: ___________________________ Social Security #: ________________________________

Get Records From: ______ Send Records To: ______

Name: ____

Address: ____

____

____ Copies of all medical records for the period of: ______ to ______

____ History & Physical Examination ____ Labs, X-ray reports, etc.

____ Other: ____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment of alcohol and/or drug abuse; or similar conditions.

The following information should NOT be released, even if occurring during the dates above:

____

____

I understand that there may be information in these records that I would not want released. I have been provided a copy of Coastal Carolina Family Practice's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure or my health information with Coastal Carolina Family Practice's Privacy Officer or other appropriate office personnel.

I understand that Coastal Carolina Family Practice assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Coastal Carolina Family Practice from all legal liability that may arise from this authorization.

Signature: ____ Date: ___________________________

If the signature above is not that of the patient, I am acting for the patient because I am the: legal guardian, parent, other (specify relationship): ____

Witness: ____ Date: ___________________________

The patient or their representative may revoke this authorization by notifying in writing Coastal Carolina Family Practice's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization as such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.