TRUESDALE MEDICAL CENTER, LLC

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Information to be released to:

Truesdale Medical Center
6296 Rivers Ave
Suite 310
N. Charleston, SC 29406
843-266-3870 phone
843-225-3674 fax

Information to be released from:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

- By initialing the space below, I authorize the following information to be released/disclosed:
  _____ Complete Medical Record

- By initialing the space below, I authorize ONLY the following information to be released/disclosed:
  _____ Office Notes _____ Radiology/Imaging _____ Lab/Pathology _____ Prescription

  _____ Other _____

- By initialing the space below, I authorize the above information released/disclosed to include:
  _____ Treatment of Drug & Alcohol Abuse
  _____ Psychological or Psychiatric Impairments
  _____ Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS)

- By initializing below, I certify (declare) the purpose of the release/disclosure is for:
  _____ Medical Review _____ Legal Review _____ Insurance _____ Continuity of Care
  _____ Other _____

I understand that I have a right to revoke this authorization at any time by notifying Truesdale Medical Center in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any revocation does not apply to the acceptable and lawful releases under the Notice of Privacy Practices.
I hereby authorize the use or disclosure of my identifiable health information as described above. The facility, its employees, officers and providers are hereby released from any legal responsibility or liability for the release and disclosure of the above information to the extent indicated and authorized herein.

I understand that I may be charged for copies of my records based on Truesdale Medical Center's policy. Current rates apply.

PATIENT NAME:_____ PATIENT PHONE: _____
PLEASE PRINT NAME

SIGNATURE: _____ PATIENT BIRTHDATE: _____
LEGAL GUARDIAN IF MINOR OR LEGAL REPRESENTATIVE

DATE: _____ Date of Expiration: _____