



TRUESDALE MEDICAL CENTER / PALMETTO COMMUNITY CARE

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Information to be released to:

Truesdale Medical Center / Palmetto Community Care
5064 Rives Avenue
N. Charleston, SC 29406
843-266-3870 phone
843-255-3674 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: _____
PLEASE PRINT NAME

PATIENT PHONE: _____

SIGNATURE: _____
LEGAL GUARDIAN IF MINOR OR LEGAL REPRESENTATIVE

PATIENT BIRTHDATE: _____

DATE: _____

Date of Expiration: _____