LOWCOUNTRY Women's Specialists
WE TAKE CARE OF YOU FOR LIFE

• 83 Springview Ln. Summerville, SC 29485
• 1801 2nd Ave., Summerville, SC 29486
P. (843) 797-3664 x 1127 F. (843) 820 –1007

Patient Name: _____

Date of Birth: _____

Social Security # (last 4 digits) XXX – XX - _____

Phone: ( ) _____

Address: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NOTE: EVERY SECTION OF THIS FORM MUST BE COMPLETED TO BE CONSIDERED VALID. Incomplete forms will not be processed. Processing fees will apply for copies of records/images and postage as provided by S.C. Law. HIPAA allows 15 days from receipt of this request for processing.

Paper
- $.65 per page for the first 30 pages, $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Max fee: $200.00
- Plus actual postage and applicable sales tax

Electronic Records:
- $.65 per page for the first 30 pages, $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Max fee: $150.00
- Plus actual postage and applicable sales tax

Important: **I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS, STDs, and / or alcohol abuse.** I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to Lowcountry Women's Specialists. I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization. Unless otherwise canceled / revoked, this authorization will expire / end one year from the date below. I understand that authorizing the disclosure of protected health information is voluntary. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information.

☐ **RELEASE** RECORDS TO

Individual/Organization: _____

Attention to: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ **Phone:** _____

REASON FOR RELEASE: ☑ Continuing Care ☐ Patient Request ☐ Legal ☐ Insurance

☐ **REQUEST** RECORDS FROM

Individual/Organization: _____

Attention to: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ **Phone:** _____

INFORMATION TO BE RELEASED

☐ Entire Record

☐ Abstract of Medical Records: History & Physical, consults, lab, radiology reports, discharge summary, Operative/procedure reports.

☐ Specific Treatment Dates _____ to _____

Printed Name of Patient or Legal Guardian: _____
(Document of representative's authority must be attached if patient is not signing)

Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____