Piedmont Family Practice
Your Medical Home

Authorization to Release Medical Information

Patient Full Name:_____ Alternate/Maiden Name:_____

Birthdate:_____ Phone # :_____ Alt. Phone #: _____

Current Address:_____

PLEASE RELEASE INFORMATION FROM:

_____

Name of Office/ Clinician Phone#

_____

Address City State Zip

INFORMATION TO DISCLOSE:
(There May be fees for Providing Copies.)
☐ General Medical Records (From the past 2 years only)
☐ Specific Dates: _____
☐ Specific Information Requested:
_____

PURPOSE OF DISCLOSURE:
☐Medical Care
☐Insurance
☐Legal
☐Transferring to New Provider
☐Other (specify):
_____

METHOD OF DELIVERY:
☐Mail
☐Fax
☐Pick up

SENSITIVE HEALTH INFORMATION:
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Please initial below if you **DO NOT** agree to release the following:
_____ Mental health treatment records
_____ Sexually Transmitted Disease (STD) treatment
_____ Genetic testing
_____ HIV/AIDS test results
_____ Alcohol/drug abuse treatment records, including Dartmouth-Hitchcock Psychiatric Associates Addiction Treatment Program (DHMC-ATP)

PERMISSION TO FAX INFORMATION: I Specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand that confidentiality at the receiving end cannot be guaranteed. **Initial:** _____

DURATION & REVOCATION:
I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Piedmont Family Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless revoked earlier, this authorization will expire 1 year from the date of signing or on** _____ (insert applicable date or event). If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Signature of Patient or Patient's Legal Representative Date

_____

PRINT Patients Legal Representative (If Applicable) Relationship to Patient

Please Release Records to:
Piedmont Family Practice
115 Beattie Park Rd, Piedmont, SC 29673
P:864-845-3331 F:864-845-3181