MEDICAL RECORDS AUTHORIZATION
HIPPA COMPLIANT FORM TO RELEASE/OBTAIN INFORMATION

NAME_____
LAST FIRST MIDDLE

SSN_____-_____-_____ DATE OF BIRTH_____TELEPHONE_____

Please give the complete name and address of the medical facility or organization you are authorizing your medical records to be released from

PHYSICIAN/CLINIC_____

ADDRESS_____TELEPHONE_____

I authorize my medical records to be sent to:

HARTH PLACE FAMILY MEDICINE
102 Harth Place
Summerville, SC 29485
Telephone (843)832-6425 Fax (843)832-6428

PLEASE READ CAREFULLY: Initial each applicable area in order to authorize release of sensitive records

_____Mental Health/Developmental Disabilities _____Abstract of medical records (past 3 years)

_____Drug/Alcohol use/abuse _____Immunization Records

_____HIV (AIDS) test results/information _____Test results

_____All medical records _____Other_____
please specify exact information

These medical records will be used for the purpose of:

_____Continuing care _____Personal copy _____Insurance claim

_____Legal claim _____Disability determination _____Other_____

This authorization is in effect from_____to_____. Upon the conclusion of this time period or event, this authorization is automatically revoked.

I further understand that:

* I may refuse to sign this authorization and that my refusal will have not impact on receiving treatment.
- I can inspect or copy any information disclosed under this agreement.
- My signing of this document is voluntary
- I can revoke this authorization at any time and the revocation must be in writing.
- I will receive a copy of this authorization
- The federal privacy6 laws will not cover this information released

Patient/Legal Guardian Signature_____Date_____

Witness Signature_____Date_____

DO NOT FAX MORE THE 25 PAGES