LADY'S ISLAND
MEDICAL CENTER

Authorization to Release Healthcare Information

Patient Name_____

Patient Date of Birth_____

I authorize: Lady's Island Medical Center
97 Sea Island Parkway, Suite 203
Lady's Island, SC 29907
Telephone: 843-379-0367 ▪ Fax: 843-379-0368

☐ to release healthcare information ***to***:

☐ to receive healthcare information ***from***:

_____
Name of Physician and/or Entity

_____
Address

(_____)_____/(_____)_____
Phone # Fax #

This request and authorization applies to:

□ Entire Record □ Immunization Records □Physician Office Notes
□ Films/Images □ Lab Results
□ Other:
Healthcare information relating to the following treatment, condition, or dates

_____

I understand that information released and/or received may include mention of drug/alcohol use, mental health care, and infectious diseases such as STDs, including HIV/AIDS.

I understand that I have the right to revoke or modify this authorization, in writing, at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state law. This authorization shall be in effect until revoked or modified by the patient in writing.

_____ _____
Patient/Guardian Signature **Date Signed**