South Strand Internists & Urgent Care

SURFSIDE BEACH
1945 Glenns Bay Rd.
Surfside Beach, SC 29575
p: 843-650-4006
f: 843-650-1418

Brian K. Adler, MD,FACP
J. Vance Vandergriff, MD
Alicia Anderson, MSN, FNP-C

PAWLEYS ISLAND
11405 Ocean Hwy.
Pawleys Island, SC 29585
p: 843-979-4006
f: 843-979-0890

Thomas N. Howard, MD
Jessica Thasitis, MSN, FNP-C

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ Date of Birth: _____ SSN: _____

hereby authorize release of my medical records from: Physician or Medical Facility _____

Address_____City/State/Zip_____

Phone #_____ Fax #_____ to the attention of:

Dr. Adler _____Dr. Howard _____ Dr. Vandergriff _____ Anderson _____ Thasitis _____

Description of the information to be released (check all that apply – *last 2 years*)

MOST RECENT:

___ Labs
___ Discharge Summary
___ Radiology Report
___ CAT Scan Report
___ OTHER_____

___ Immunization Record
___ EKG
___ Ultrasound Scan
___ MRI Report
___ **All chart contents**

Patient information is needed for: ***(Please check one below)***

___Continuing Medical Care ___Moving ___Leaving Practice ___Other:_____

- I understand that I may inspect or copy the protected health information described by the authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations.
- I understand that I may revoke or terminate this authorization by submitting a written revocation to South Strand Internists.
- I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (Aids) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my HIPAA rights pertaining to the release of my 6medical information and the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

***** This authorization expires 1 year from date of request.***

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name (print): _____