South Strand Internists & Urgent Care

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. Brian Adler (fax: 843- 650-1418)

_____Dr. J. Vance Vandergriff (fax: 843- 903-5232)

_____Katherine Freeman, FNP (fax: 843- 650-1418)

_____Alicia Anderson, FNP (fax: 843- 903-5232)

_____Rachel Dorr, NP (fax: 843- 903-5232)

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

MOST RECENT:

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

___ Immunization Record
___ EKG
___ Ultrasound Report
___ 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 medical 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): _____

(Revised: April 5, 2022)