FAMILY MEDICINE ASSOCIATES
PIEDMONT WEST OFFICE

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Phone: _____ Social Security Number: _____

Address: _____
STREET CITY STATE ZIP CODE

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

( ) Progress/Physician Notes – 2 most recent ( ) Laboratory Reports – most recent ( ) Diagnostic Radiology Reports – last 2 years

( ) Other _____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION: By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category indicated next to the box, if any, pursuant to this authorization.

( ) Information about mental health or mental retardation services ( ) Psychotherapy notes created by a mental health professional
( ) Information about HIV/AIDS related testing ( ) Information about sexually transmitted diseases
( ) Information about sexual assault ( ) Information about child abuse and neglect
( ) Information about alcohol or drug abuse treatment program services

Name of Physician/Practice who may disclose my health information: _____

To release records to: **Family Medicine Associates – Piedmont West**
1190 Filbert Highway
York, SC 29745
Phone Number: (803) 324-3636
Fax Number: (803) 324-3606

Term: This authorization will remain in effect: ( ) From the date of this authorization until the ___day of _____,20_____
( ) Until _____fulfills this request
( ) Until the following event occurs: _____
( ) Other: _____

I understand that once my health information has been disclosed to the recipient, the medical facility releasing my health information cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that the health facility may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke, at any time, this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the health facility; except, however, if my treatment at the health facility is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case the health facility may refuse to treat me if I do not sign this authorization.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to the health facility's Privacy Office at the practice address. The revocation will be effective immediately upon the health facility's receipt of my written notice, except that the revocation will not have any effect on any action taken by the practice in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Family Medicine Associates – Piedmont West to use or disclose my health information in the manner described above.

_____
Signature of Patient or Parent/Guardian

Date: _____