Providence MEDICAL GROUP

PMG Physician:_____

Authorization to Disclose Protected Health Information
The undersigned authorizes:
Providence Medical Group
110 Gateway Corporate Blvd, Suite 100, Columbia, SC 29203
(P) (803) 865-4490 (F) (803) 255-2785
to release my health information as noted below:

1. Patient Information

Patient Full Name: _____ **Other Names?** _____ Patient

Address: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____ Phone #: _____

2. Release Information To

Email address for record delivery only: *Please ensure email address is legible!* Provide email address only if you want your records sent via email.

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.****Full address and phone # must be provided even if you are wanting records emailed****

Name/Facility: _____ **Attention:** _____

Address: _____ Phone: _____ City: _____ **S**tate: __ ____Zip: _____

Fax #_____

Purpose of Request: ___ Personal ___ Treatment ___Legal ___Insurance ___Transfer ___Other:

3. Information to be Released

If you fail to specify, a 1-year abstract will be provided.

___Please release a **1-year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2-year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**: _____:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

4.

(**Please pick ONE delivery option**)

[ ] Send by Email	**[ ] Fax to Doctor**	**[ ] Records on Paper**

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed South Carolina Code Ann. § 44-115-80 (2014)

5. Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(*Please Initial*)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this**

6.

Signature*: _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy -of the legal documentation for patient's representative must be supplied with a copy of this form.*

1. Patient Information: Ensure the patient fills out this entire portion with full name (along with any nicknames or previous names used), address, and DOB. Please include the Physician's name you are needing records from on the PMG Physician line at the top of the form. Patient home address and phone number must be provided even if records are to be emailed.
2. Release Information To: We need the full name and address of where the patient is wanting records sent and would need a fax number included to electronically send records to another doctor. ****Full address and phone # must be provided even if you are wanting records emailed****
3. Information to be Released: The patient needs to make a selection as to what they are wanting released. If they do not make a selection, we default to sending a 1-year abstract of records.
4. Delivery Option: This option allows us to know exactly how the patient is wanting the records delivered, via: email, fax or paper copies.
5. Release Information To: Only applicable to any sensitive information that may be in the chart. If this is not initialed, we will not include any of this info in the record set that is sent.
6. Signature: Unless records are being sent to doctor's office, the patient MUST sign and date the auth or it will not be processed.