

Saluda Medical Center
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients **full** name)

Birth date (Mo/Day/Yr)

(Street address)

_____-_____-_____
Social Security Number (xxx)-(xxx)-(xxxx)

(City, state, zip code)

Phone (Home) (area + Number)

At the request of the individual, I _____ do hereby authorize _____ to release:
(Patient Name) (Name of Facility)

Dates of _____

DISCHARGE SUMMARY _____ PATHOLOGY REPORTS _____ EMERGENCY REPORTS

HISTORY & PHYSICAL _____ LABORATORY REPORTS _____ OTHER: _____

PROGRESS NOTES _____ RADIOLOGY REPORTS _____

OPERATIVE NOTES _____ EGG/EEG/CARDIC CATH _____

___ I do ___ I do NOT authorize release of information related to AIDS (Aquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

Street Address

City, state, ZIP

PURPOSE OF DISCLOSURE:
___ REFERRAL TO SPECIALIST ___ INSURANCE ___ WORKERS COMP ___ CHANGE OF DOCTOR
___ LEGAL INVESTIGATION ___ DISABILITY DETERMINATION ___ PERSONAL ___ CONTINUING CARE
OTHER (SPECIFY) _____

Please provide current telephone number in the even we need to contact you:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Personal Representative of patient's estate **Date** _____

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. Smart Corporation has been contracted to provide this service and will invoice you directly.

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUN _____
OP _____ X-RAY _____ OTHER _____
HP _____ PATH _____

ROI SPECIALIST

DATE

NUMBER OF PAGES _____