Family Physicians of Spartanburg
Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: ____/____/____
Address: _____ Social Security #: ____-___-_____
_____ Telephone: (___) ____-_____

Information to be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check the type of information to be released:

- ☐ Entire medical record
- ☐ History and physical exam
- ☐ Laboratory test results/reports
- ☐ Operative report
- ☐ Pathology report
- ☐ Consultation report
- ☐ X-ray reports
- ☐ Emergency room record
- ☐ Discharge summary
- ☐ Progress notes
- ☐ Itemized bill
- ☐ Other _____

Purpose of Request

- ☐ Treatment or consultation
- ☐ Other _____
- ☐ At the request of the patient
- ☐ Billing or claims payment

***** Notice: In some cases, the copying of medical records is processed by an outside company that charges a fee for service. Therefore, it is the patient's responsibility to compensate these costs. The copy service will mail a statement to patient in the event that services are charged. If the charges are not compensated, the records will not be released to the receiving practice. _____Initials**

Release information from this practice:	**To this practice:**	**Person Authorized to Receive Information:**
_____	**Family Physicians of Spartanburg**	_____
_____	**3021 Reidville Road**	_____
_____	**Spartanburg, SC 29301**	
	Ph: (864) 576-9201 Fax: (864) 576-6584	

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to this release.

Check one: ☐ **Yes** ☐ **No** **_____Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to this release.

Check one: ☐ **Yes** ☐ **No** **_____Initials**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the practice. Unless revoked, this authorization will expire on the following date or event _____. If no expiration date is set forth, this authorization will expire 180 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that the practice may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Family Physicians of Spartanburg to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____
Identity of requestor verified via: (Circle one) Photo ID Matching Signature Other _____
Verified by: _____