**Piedmont Medical Center**

*AUT_REL_MED*

EZ-7003 AUT REL MED R03/2013

I authorize Piedmont Medical Center to disclose the following information from the health record of:

| | | | |
|---|---|---|---|
| **PATIENT INFORMATION** | **Patient Name** _____ **Date of Birth** _____ **MR#** _____<br>**Address** _____ **Phone Number** _____<br>**City** _____ **State** _____ **Zip** _____ | | |
| **INFORMATION REQUESTED**<br>**Service Dates From:** _____<br>**To:** _____ | ☐ All Pertinent Records (includes those listed below)<br>☐ Discharge Summary<br>☐ History & Physical<br>☐ Lab results<br>☐ Consultations<br>☐ ER Report<br>☐ Operative Report<br>☐ Pathology Report | ☐ Discharge Instructions<br>☐ X-ray Reports<br>☐ Imaging and/or imaging reports<br>☐ Behavioral Health/Psychiatric Care Record<br>☐ Screening and/or Treatment of Alcohol and/or Substance Abuse<br>☐ EKG Report | ☐ Specify: _____<br>☐ All Records |
| **PURPOSE** | ☐ Self ☐ Continuing Medical Care ☐ Other (specify reason):_____ | | |
| **INFORMATION TO BE GIVEN TO** | **Company, Person, Facility Name** _____ **Phone Number** _____<br>**Address** _____ **City** _____ **State** _____ **Zip** _____ | | |

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable disease, Behavioral health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Piedmont Medical Center will not condition or deny treatment on my signing this authorization, unless the healthcare to be provided is research-related treatment and the use or disclosure of information is for such research.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Piedmont Medical Center's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Piedmont Medical Center, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

**I may contact Piedmont Medical Center's Privacy Office by mail at Privacy Office, 222 S Herlong Avenue. Rock Hill, SC 29732**
**E-mail at PMC-Privacy@tenethealth.com**

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 Piedmont Medical Center to use or disclose my health information in the manner described above.

**Signature of Patient** _____ **Date** _____

In requesting the medical records as the designated agent, in signing below, I attest to the continuing in ability of the above patient to make or communicate health care decisions.

**Signature of Legal Representative** _____ **Relationship to Patient or Description of Authority to Act for Patient** _____ **Date** _____

**For Healthcare Use Only**
**Employee completed/reviewed form with patient:** _____ **ID verified:** _____
**Date Received:** _____ **Date Sent:** _____ **Processor:** _____

**Authorization to Use and Disclose PHI**

«PatientNumberBarcode»

«AdmitDate»

**ACCT#:«PatientNumber» MR#:«MedicalRecordNumber»**
**«PatientName» «Age»«AgeCode» «Gender»**