Piedmont Medical Center



EZ-7003 AUT REL MED R03/2013

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

INFORMATION				_
	Patient Name		Date of Birth	MR#
	Address		Phone Number	
	City	State Zip		
INFORMATION REQUESTED	☐ All Pertinent Records (includes those listed below) ☐ Discharge Summary	□ Discharge Instructions □ X-ray Reports □ Imaging and/or imaging reports	□ Specify:	
Service Dates	□ History & Physical	☐ Behavioral Health/Psychiatric Care Re		
From:	□ Lab results □ Consultations	 Screening and/or Treatment of Alcoholand/or Substance Abuse)	
То:	□ ER Report□ Operative Report	□ EKG Report		
	□ Pathology Report		□ All Record	S
PURPOSE	☐ Self ☐ Continuing Med	I dical Care ☐ Other (specify reason):_		
INFORMATION TO BE GIVEN TO	Company, Person, Facility Name		Phone Number	
	Company, rerson, racinty war	ne .	i none Number	
	Address	City	State	Zip
		nclude information relating to Sexually Trar /) and other communicable disease, Beha ature authorizes release of any such inform	vioral health Care/Psy	
alcohol and/or drug a may refuse to sign authorization, unless	abuse and genetic testing; my signa this authorization form. I understan s the healthcare to be provided is re	//) and other communicable disease, Beha ature authorizes release of any such inform and that Piedmont Medical Center will not co search-related treatment and the use or di	vioral health Care/Psy nation. ondition or deny treatn isclosure of informatio	chiatric Care, treatment on ment on my signing this n is for such research.
alcohol and/or drug a may refuse to sign authorization, unless understand that I m	abuse and genetic testing; my signa this authorization form. I understan s the healthcare to be provided is re hay revoke this authorization at any	 /) and other communicable disease, Beha ature authorizes release of any such inform at that Piedmont Medical Center will not contain. 	vioral health Care/Psy nation. ondition or deny treatn isclosure of informatio ed on this authorization	chiatric Care, treatment on the control of the cont
alcohol and/or drug a I may refuse to sign authorization, unless I understand that I m Piedmont Medical Co	abuse and genetic testing; my signathis authorization form. I understants the healthcare to be provided is remay revoke this authorization at any enter's Notice of Privacy Practices of	//) and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distince, except to the extent that action base	vioral health Care/Psy nation. ondition or deny treatn isclosure of information ed on this authorization includes a request in	chiatric Care, treatment on ment on my signing this in is for such research. In has already been taken. writing.
alcohol and/or drug a I may refuse to sign authorization, unless I understand that I m Piedmont Medical Co Unless I revoke this	abuse and genetic testing; my signathis authorization form. I understant the healthcare to be provided is remay revoke this authorization at any enter's Notice of Privacy Practices authorization earlier, it will expire the second of the sec	/) and other communicable disease, Beharature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distime, except to the extent that action base explains the process for revocation, which the months from the date signed or as special party, the information may no longer be	vioral health Care/Psynation. condition or deny treatmisclosure of information and on this authorization includes a request in ecified:	chiatric Care, treatment on the second of th
alcohol and/or drug a I may refuse to sign authorization, unless I understand that I m Piedmont Medical Co Unless I revoke this I understand that, if t re-disclosed by the p I release Piedmont N	abuse and genetic testing; my signal this authorization form. I understant the healthcare to be provided is replay revoke this authorization at any enter's Notice of Privacy Practices of authorization earlier, it will expire this information is disclosed to a third berson or organization that receives Medical Center, its employees and a	/) and other communicable disease, Beharature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distime, except to the extent that action base explains the process for revocation, which the months from the date signed or as special party, the information may no longer be	vioral health Care/Psynation. condition or deny treatment is closure of information and on this authorization includes a request in ecified: protected by state, fee	chiatric Care, treatment on my signing this in is for such research. It has already been taken, writing. deral regulations and may
alcohol and/or drug a I may refuse to sign authorization, unless I understand that I m Piedmont Medical Co Unless I revoke this I understand that, if t re-disclosed by the p I release Piedmont M liability for the disclose	abuse and genetic testing; my signal this authorization form. I understant the healthcare to be provided is replay revoke this authorization at any enter's Notice of Privacy Practices authorization earlier, it will expire this information is disclosed to a third berson or organization that receives Medical Center, its employees and a sure of the above information to the	/) and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distinct, except to the extent that action base explains the process for revocation, which the months from the date signed or as specific party, the information may no longer be the information.	vioral health Care/Psynation. condition or deny treatmisclosure of information and on this authorization includes a request in ecified: protected by state, feets associates from an	chiatric Care, treatment of the content on my signing this on is for such research. It has already been taken, writing. deral regulations and may be legal responsibility or
alcohol and/or drug a lamay refuse to sign authorization, unless authorization, unless I understand that I meledmont Medical Counless I revoke this I understand that, if the re-disclosed by the part of the disclosed I may contact Piedre-E-mail at PMC-Privation of my health inform	abuse and genetic testing; my signal this authorization form. I understant the healthcare to be provided is recapt revoke this authorization at any enter's Notice of Privacy Practices authorization earlier, it will expire this information is disclosed to a third berson or organization that receives Medical Center, its employees and a sure of the above information to the mont Medical Center's Privacy Of acy@tenethealth.com	// and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distince, except to the extent that action base explains the process for revocation, which the months from the date signed or as specific party, the information may no longer be the information. Agents, medical staff members and busines extent indicated and authorized herein.	vioral health Care/Psynation. condition or deny treatmisclosure of informationed on this authorization includes a request in protected by state, feets associates from an arlong Avenue. Rock	chiatric Care, treatment of the content on my signing this in is for such research. In has already been taken, writing. I deral regulations and may be a legal responsibility or thill, SC 29732 Se and disclosure
alcohol and/or drug a may refuse to sign authorization, unless understand that I meledmont Medical Counless I revoke this understand that, if the disclosed by the purelease Piedmont Miability for the disclosed I may contact Piedre-E-mail at PMC-Prival I have read and un of my health information in Signature of Patic In requesting the may refuse to signature of Patic In requesting the may hauthorized to signature of Patic In requesting the may refuse to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In requesting the may request to signature of Patic In request to signature of Patic In request to signature of Patic In request to s	abuse and genetic testing; my signal this authorization form. I understant the healthcare to be provided is recapt revoke this authorization at any enter's Notice of Privacy Practices of authorization earlier, it will expire this information is disclosed to a third berson or organization that receives Medical Center, its employees and a sure of the above information to the mont Medical Center's Privacy Office Medical Center of this Authorization. By my signature, I hereby, kin the manner described above.	A) and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distinct, except to the extent that action base explains the process for revocation, which to months from the date signed or as specific party, the information may no longer be the information. Agents, medical staff members and busines extent indicated and authorized herein. Effice by mail at Privacy Office, 222 S Hereiting and I have had an opportunity to ask	vioral health Care/Psynation. condition or deny treatm isclosure of informationed on this authorization includes a request in ecified: protected by state, feets associates from an arlong Avenue. Rock questions about the upont Medical Center to a	chiatric Care, treatment of the content on my signing this in is for such research. In has already been taken, writing. I have already been taken, writing. I deral regulations and may be y legal responsibility or the content of t
may refuse to sign authorization, unless understand that I meledmont Medical Country and the previous Previous I revoke this auderstand that, if the disclosed by the prelease Piedmont Maibility for the disclosed may contact Piedre-mail at PMC-Prival I have read and un of my health information Signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie In requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may request the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may refuse to signature of Patie II requesting the may request the	abuse and genetic testing; my signal this authorization form. I understant the healthcare to be provided is recapt revoke this authorization at any enter's Notice of Privacy Practices of authorization earlier, it will expire this information is disclosed to a third berson or organization that receives dedical Center, its employees and a sure of the above information to the mont Medical Center's Privacy Of acy@tenethealth.com Iderstand the terms of this Authorization. By my signature, I hereby, kein the manner described above.	A) and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or distinct, except to the extent that action base explains the process for revocation, which to months from the date signed or as specific party, the information may no longer be the information. Agents, medical staff members and businese extent indicated and authorized herein. Affice by mail at Privacy Office, 222 S Hereit and I have had an opportunity to ask anowingly and voluntarily authorize Piedmonth.	vioral health Care/Psynation. condition or deny treatmisclosure of informationed on this authorization includes a request in protected by state, fewards associates from an arlong Avenue. Rock questions about the upont Medical Center to be a pate nuing in ability of the a pate.	chiatric Care, treatment of the content on my signing this in is for such research. In has already been taken, writing. I have already been taken, writing. I deral regulations and may be y legal responsibility or the content of t
may refuse to sign authorization, unless understand that I meledmont Medical Country and the property of the p	abuse and genetic testing; my signal this authorization form. I understant is the healthcare to be provided is reliantly revoke this authorization at any enter's Notice of Privacy Practices of authorization earlier, it will expire this information is disclosed to a thir berson or organization that receives Medical Center, its employees and a sure of the above information to the mont Medical Center's Privacy Of acy@tenethealth.com Inderstand the terms of this Authorization. By my signature, I hereby, keen the manner described above.	A) and other communicable disease, Behavature authorizes release of any such informed that Piedmont Medical Center will not consearch-related treatment and the use or disearch-related treatment and the use or distince, except to the extent that action base explains the process for revocation, which is months from the date signed or as specific party, the information may no longer be the information. Agents, medical staff members and businese extent indicated and authorized herein. Affice by mail at Privacy Office, 222 S Head ation and I have had an opportunity to ask knowingly and voluntarily authorize Piedmongent, in signing below, I attest to the continuationship to Patient or	vioral health Care/Psynation. condition or deny treatmisclosure of information and on this authorization includes a request in protected by state, feet as associates from an arlong Avenue. Rock questions about the upont Medical Center to a pate nuing in ability of the arror Patient	chiatric Care, treatment of the chiatric Care, the chiat

Authorization to Use and Disclose PHI

«PatientNumberBarcode»

«AdmitDate»