DUNCAN REGIONAL HOSPITAL
AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_______________________________ Medical Record #:_______________________
Date of Birth:_______________________________ Social Security #:_______________________

I am requesting that Duncan Regional Hospital disclose information in my medical record to:_______________________at this address____for this purpose_______________________.
I understand that Duncan Regional Hospital may assess a per page fee for making copies of my medical record.
I am authorizing the following information to be used or disclosed:

Patient Type: ___Emergency Rm. ___Inpatient ___Outpatient ___Outpatient Surgery

Dates of Treatment, if known:___________________

Information to be released:

☐ History and Physical	☐ X-ray Reports	☐ Operative Reports
☐ Laboratory Reports	☐ Discharge Summary	☐ X-ray Films (See Radiology section below)
☐ Pathology Reports	☐ Progress Notes	☐ Orders
☐ EKG/ECHO	☐ Emergency Room	☐ Other:_______________________

RADIOLOGY

I understand that by signing this release I acknowledge that I am responsible for keeping these films, and if they need to reprinted for any reason, there will be a charge of $5.00 per sheet. Additional CD's will be made at no charge,_____________ (Initial)

This Authorization will expire in: ☐ **One Year** ☐ **On (specific date or event)**_____________________

This authorization ☐ **does** ☐ **does not extend to information placed in my medical record after the date I sign this form.**

☐ I request the information be faxed to the following fax number:_____________________

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Joint Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the above event.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that the information that I have authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

____ _________________________________
Signature of Patient or Legal Representative Date

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Description of Legal Representative's Authority