24 HOUR ANSWERING SERVICE OFFICE HOURS BY APPOINTMENT

LAKE COUNTY MEDICAL GROUP, SC

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Authorization for Disclosure of Health Records

(1) I authorize ______________________________ to disclose the following information from the health records of:

Patient Name: ______________________ Date of Birth: ______________________

Address: ____

Telephone: ______________________ Patient Number: N/A ______________________

Social Security Number: ______________________

Covering the period (s) of healthcare:

From (date) ______________________ To (date) ______________________

From (date) ______________________ To (date) ______________________

(2) Information to be disclosed:

[ ] Complete health records (s) [ ] Progress Notes
[ ] Discharge Summary [ ] Laboratory Tests
[ ] History and Physical Examination [ ] X-Ray Reports
[ ] Consultation Reports [ ] Photographs, videotapes, digital or other images

[ ] Other (please specify) ____

Please note that a special release form needs to be signed for release of HIV results.

(3) This information is to be disclosed to ____

For the purpose of ____

(4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____

____

(5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above in information to the extent indicated and authorized herein.

____

Signature of Patient or Legal Representative Date

____

Signature of Witness Date