



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

- Roper Hospital
- Roper Berkeley
- Bon Secours St. Francis Hospital
- Roper Saint Francis Physician Network

_____ is hereby granted authorization to release copies of medical records on:

Patient's Name: _____

Date of Birth: _____ SSN #: _____ Phone #: _____

Date(s) of Service Requested: _____

Information Requested: _____

Purpose of Disclosure: _____

Released By: _____

Released To: _____

Address: _____

- ◆ I understand that this information may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse and results of tests for all infectious diseases including AIDS/HIV.
- ◆ I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department in writing.
- ◆ I understand that revocation will not apply to information that has already been released in response to this authorization.
- ◆ I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- ◆ I understand that authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization.
- ◆ I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- ◆ I understand that this authorization will automatically expire ninety (90) days from the date it is signed unless revoked sooner.

Signature of Patient or Legal Representative

Dated this _____ day of _____ (year)

Revised: November 15, 2002

