Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	SSN (optional):
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

This authorization will automatically expire 90 days from the date of the authorization is signed, unless the individual specifies an earlier date. Upon the conclusion of that time period, this authorization is automatically revoked and no further use or disclosure of the patient's PHI is permitted beyond that date.

What records do you want? (Check appropriate boxes below):

Date(s) of Service: _____/_____/_____ through _____/_____/_____

☐ Discharge Summary ☐ History & Physical ☐ ED Records ☐ Consultations ☐ EKG ☐ Therapy Notes
☐ All PHI ☐ Operative/Procedure Reports ☐ Billing Records ☐ Labor/Delivery Summary ☐ Admission facesheet
☐ Lab/Pathology Results ☐ Radiology Results ☐ Anesthesia Record ☐ Physician Orders ☐ Progress Notes
☐ Nursing Information ☐ Transfer Forms
☐ Other (Immunization Records, Medication Lists) Please specify: _____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that is strictly voluntary.
2. If I do not sign this form, my health acre and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or received is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations and may be disclosed.
5. I will receive a copy of this form after I sign it.

I would like my records from the following Aiken Regional Medical Centers Facilities:

☐ Aiken Regional (Hospital) ☐ Aurora Pavilion ☐ Hitchcock Rehabilitation ☐ Palmetto Pediatrics

How would you like your records delivered?

☐ **Paper options:** ☐ Mailed to your Home ☐ In-Person Pickup
☐ **Electronic options:** ☐ E-mail ☐ CD

Where do you want the information sent? (Fill in boxes below):

Aiken Regional Medical Centers should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient/Guardian or Personal Representative	**Relationship to Patient (please print)**
Print Name	**Date/Time**

Aiken Regional Medical Centers recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801

Patient Request for Health Information

Patient Identification


RI1100

10-1989
902.03
Rev. 10/20