Patient Name:	Birth Date:	Social Security No. *(optional)*
Patient name at time of treatment if different than above:	Requester's Name:	
Purpose of disclosure: ☐ Medical treatment ☐ Military ☐ Insurance Company ☐ Other ☐ Personal Reasons ☐ Attorney	Address 1: City: State: Zip: Name and address of recipient if different than above:	

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.

I authorize _____ to release the following health information:
(healthcare provider)

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI* in medical record		☐ ED Information		☐ Laboratory Tests	
☐ Admission facesheet		☐ Physician Orders		☐ EKG	
☐ Discharge Summary		☐ Progress Notes		☐ Therapy Notes	
☐ History & Physical		☐ Labor/Delivery Summary		☐ Billing Record:	
☐ Consultation Reports		☐ Nursing Information		☐ Other:	
☐ Operative Reports		☐ Transfer Forms		☐ Other:	
☐ Anesthesia Record		☐ Radiology Reports		☐ Other:	

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 it is strictly voluntary.
2. If I do not sign this form, my health care 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 any 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 federal privacy regulations and may be disclosed.
5. I will receive a copy of this form after I sign it.

FEES:

$.65/page for the first 30 pages (plus tax)
$.50/page thereafter (plus tax)

If the entire record is requested the requester will be notified of the total charge and prepayment may be required.

SIGNATURES:

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

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name:	Relationship to Patient:
Signature of Witness:	Print Name of Witness:

Aiken Regional Medical Center
302 University Parkway
Aiken, SC 29801

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

RI0010

Patient Identification