Aesthetic Medical Center 911 Medical Circle, Myrtle Beach SC 29572 Tel: 843-945-9990 Fax: 843-945-9991

Authorization - Release of Protected Health Information

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate: ____/___/____ Social Security Number: _____ - ____ - _____ email:_____

Address (number and street): _____

City: _____ State: _____ Zip Code: _____ Phone: (____) _____ - _____

I hereby authorize and request Aesthetic Medical Center To: □ Release information to / or Obtain information from
Name/Facility_____
Address_____
City, State, Zip _____
FOR THE PURPOSE _____

Information to be Released/Obtained: Please check appropriate areas and specify treatment/test date(s) □

□Entire medical file □ □Emergency Dept (not admitted) Date(s) _____ □

□Same Day/Outpatient Procedure Date(s) _____ □ □Inpatient, Admission Date(s) _____ □

□Other (specify) _____ Date(s) _____

Specified Reports: □

□Complete Medical Record □ □Consultation Report □ □Cardiology Report □□ Interdisciplinary Notes □Abstract □ □ Emergency Dept □ □Radiology Report □ □Mental Health Consultations/Evaluations □□ Admission/Face Sheet □ □Laboratory Report □ □Radiology Films □ □Radiation Therapy □ □Discharge Summary □ □Operative Report □ □Medication Sheet □ □Immunization Record □ □History and Physical □ □Pathology Report □ □Doctor's Orders □ □Doctor's Notes □ □Pathology Slides □ □Nurses Notes □ _____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

□Genetic Information □Treatment for alcohol and/or drug abuse □ Sexually Transmitted Disease(s)
□Communicable Disease(s) □AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection □Psychiatric

I authorize the above person/organization and /or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested. I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon.

I understand that this authorization will expire on _____. **If I fail to specify an expiration date, event or condition, this authorization will expire in six months. (Insert date or event)**

I understand that authorizing the disclosure of this health information is voluntary.

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Authorization - Release of Protected Health Information

I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

Signature of Patient or Legal Representative_____ Date_____

If signed by Legal Representative, Relationship to Patient_____

Signature of Witness _____ Date_____

NOTICE TO RECIPIENT OF INFORMATION PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CRF Part 2) prohibits you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization - Release of Protected Health Information

Upon receipt of proper request in writing, all requests will be processed. Copies of medical records will be provided within thirty days of receipt of proper request in writing and payment: FEES: $1.00 per page for first 100 pages, not to exceed $100.00 for the entire record. If the record is less than 10 pages, a $10.00 fee will be charged.

ABOVE FEE IS NOT APPLICABLE FOR THE FOLLOWING:

1. Records mailed directly to a Physician/Health Care Facility The facility will mail copies of requested records directly to a Physician/Health Care Facility at no charge to the patient.
2. Medical Emergency Case (records needed for medical care within 48 hrs or less) Written consent by Patient/Patient Representative is required. Arrangements will be made for a scheduled pickup, or records may be faxed per direct request from treating physician. The physician's name, address, phone number, fax number (if applicable), and appointment time is mandatory for above transaction.