ReGenesis Health Care

My Family. My Doctor. My Choice.

Address: PO Box 5158, Spartanburg SC 29304

Phone (864)582-2411 **Fax** (864)582-7178

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF HEALTH INFORMATION

My signature below hereby voluntarily authorizes the release or disclosure of my health information. (Only one patient per authorization)

Patient Name:	**DOB:** **SSN:**
I hereby authorize ReGenesis Health Care to:	☐ **RELEASE** and/or **EXCHANGE** specified information from my record to the following: **OR** ☐ **OBTAIN** specified information from the following:
Address, Phone Number or Fax Number: **(of Person/ Facility/ Doctor's Office** **Address:**_____ **Phone #:**_____ **Fax #:**_____	**NAME OF PERSON/ FACILITY/ DOCTOR'S OFFICE:** _____

II. The purpose of this disclosure is for continuity of care or (list reason) _____.

III. The information to be disclosed from my health record: (check the appropriate box(es) and circle documents to be released)

- ☐ **Office Visit Note** Most Recent Only or Specifically:_____
- ☐ **Lab/Pathology Results** Most Recent Only or Specifically:_____
- ☐ **Radiology Reports** Most Recent Only or Specifically:_____
- ☐ **Immunization Records** Most Recent Only or Specifically:_____
- ☐ **Inpatient/Birth/ER Records** Most Recent Only or Specifically:_____
- ☐ **Dental Xrays** Most Recent Only or Specifically:_____
- ☐ **Other:**_____

I also authorize by my signature below the following sensitive information to be disclosed according to 42 CFR Part 2 (check the applicable box(es) and sign). This information will not be released unless signed here in addition to the bottom of page:

- ☐ **Alcohol/Drug Abuse Treatment/Referral**
- ☐ **Sexually transmitted Disease**
- ☐ **HIV/AIDS-related treatment**
- ☐ **Mental Health (Other than Psychotherapy Notes)**

Patient Signature_____ **Date:** _____

- I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 LISC 552a].
- I may revoke this authorization by notifying this practice in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization expires on: _____

SIGNATURE OF PATIENT	DATE:
SIGNATURE OF AUTHORIZED REPRESENTATIVE (State relationship to patient) or Witness (if signature is thumbprint or mark)	DATE:

Record Copy Fee Paid: _____
Witness Signature: _____ **Date/Time Witnessed:**_____
Patient's Phone Number:_____ **Patients, please allow 7-10 business days for the completion of this request**