ANMED HEALTH

LABEL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ M.R.#: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. I am authorizing **AnMed Health or** _____ to make the following disclosure.
3. The type of information to be released is: Date of visit and encounter #
   - ___ Physician Dictations (History and Physical, Discharge Summary, Consult Note, Procedure Note) _____
   - ___ Emergency Room Record _____
   - ___ Urgent Care Record _____
   - ___ Medication List _____
   - ___ Laboratory Results _____
   - ___ Radiology Reports _____
   - ___ Entire Record _____
   - ___ Other _____
     _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or substance abuse.
5. This information may be disclosed to and used by the following individual or organization:
   _____ Address: _____
   for the purpose of: _____
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand 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. If I have questions about the disclosure of my health information, I can contact the Medical Records Department at (864) 512-1258.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness