AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient Name:			**Birth Date:**	**Phone No.:**	
Authorization to <u>Release</u> the Protected Health Information is given to the following person and/or organization: **Name of Person/Organization authorized to release your protected health information:**			**Authorization to <u>Receive</u> the Protected Health Information is given to the following person and/or organization:** **Name of Person/Organization authorized to receive your protected health information:** **CPG Waccamaw Cardiology**		
Address:			**Address:** **2376 Cypress Circle Suite 102**		
City:	**State:**	**Zip:**	**City:** **Conway**	**State:** **SC**	**Zip:** **29526**
Phone #:	**Fax #:**		**Phone #:** **843.347.8953**	**Fax #:** **843.347.0226**	

This authorization will expire in **90 days** unless otherwise specified below:

Purpose of the information (Reason for disclosure):

Description of information to be used or disclosed

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
All PHI in medical record History and Physical Office visit notes Laboratory test results Radiology Films		Billing record: Other: 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. 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.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. If requested, I may receive a copy of this form after I sign it.

Section B: Signatures	
I have read the above and authorize the disclosure of the protected health information as stated.	
Parent/Guardian/Representative's Signature:	**Date:**