Magnolia Family Practice
John R. Fleming, Jr., MD, FAAFP
Jennifer K. Weich, FNP-C
1229 Alice Drive
Sumter, SC 29150
803-905-CARE (905-2273)

Authorization To Disclose Health Information

Date of request: _____

Patient's Name: _____

Date of Birth: _____

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I also understand that the information used or disclosed under this authorization may be subject to re-disclosure by the recipient.

Purpose of Release:
1) Medical Care X 2) Legal Representation____ 3) Other Transfer of Care

Information Request From:

Name: Palmetto Health USC Medical Group Family Medicine - Palmetto Family Practice

Address: 115 N. Sumter Street, Suite 315

Sumter, SC 29150

Phone: 803-934-0810 Fax: _____

Information Requested:

☐ Office notes	☐ All	☐ Period of time: _____
☐ Labs	☐ All	☐ Period of time: _____
☐ Xrays/EKG's	☐ All	☐ Period of time: _____
☐ Hospitalizations	☐ All	☐ Period of time: _____

☐ Other: _____
☐ Most recent provider note
☒ Entire record ***PLEASE SEND ALL RECORDS ELECTRONICALLY THROUGH P2P***

I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.

I hereby authorize the release of any and all information from my medical record as indicated above to *Magnolia Family Practice.*

_____ _____
Signature of patient/legal representative Date

_____ _____
Relationship to patient Witness