Magnolia Family Practice
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Sumter, SC 29150
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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_____

Information Request From:

Name: _____

Address: _____

_____

Phone: _____ 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

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