Oconee Pediatrics, PA
15579 Wells Highway
Seneca, SC 29678
Office: 864-882-7800
Fax: 864-882-5908

Authorization To Use Or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information described below:

_____ _____ _____

Patient Name **Date of Birth** **Social Security Number**

_____ _____

Address(street,city,state, zipcode) **Telephone number**

The following individual or organization is authorized to make the disclosure(coming from)

_____

Telephone number of the organization or individual_____Fax number_____

(information coming from)

This information may be disclosed to and used by the following individual or organization

_____

(information going to)

Telephone number of the organization or individual_____Fax number_____

Purpose of request:_____

The following information is to be disclosed: **PLEASE DO NOT FAX OVER 10 PAGES**

___Physician notes
___Lab results
___X-ray reports
___MRI scans
___Cardiac studies
___COMPLETE MEDICAL RECORD INCLUDING RECORDS CONTAINED WITHIN FROM OTHER SOURCES

__Initials I understand that the information in my record may include information relation to sexually transmitted diseases, Acquired Immunodeficiency Syndrome(AIDS), or infection with the Human Immunodeficiency Virus(HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

__Initials I understand that any disclosure of information carries potential for redisclosure and that the information then may be protected by federal confidentiality rules.

__Initials I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

__Initials I understand that authorizing the disclosure of this health information is voluntary.

__Initials I understand that I may inspect or obtain a copy of the information to be used or disclosed.

_____

Signature of Patient or Legal Representative **Date of release_____**

Date release will expire_____

(not to exceed 6 months)

_____

If not patient, relationship of legal representative to patient

****ALL INFORMATION MUST BE COMPLETE TO RELEASE MDICAL RECORD****

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