Palmetto Health USC
MEDICAL GROUP

Authorization for the Use and Disclosure of Protected Health Information

____ _______________________________ __________________
Patient Name DOB MRN

I hereby authorize Palmetto Health USC Medical Group (hereinafter "Medical Group") to use or disclose my protected health information as described below. I understand that the information I authorize a person/facility to receive may be subject to re-disclosure by the recipient and may no longer be protected state and federal regulations.

Information to be Used/Disclosed – Please check those that apply:

___ History & Physical ____Discharge Summary ___Operative Report ___Entire Medical Record
___ Progress Notes ____Laboratory Report ___ Radiology Report ___Immunization Record
___ Billing Summary ____Consultation Report ___ Pathology Report ___ Other (Specify) ______________________

Date(s) of Treatment: ____

Entity Providing Information (Address)

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Person or Entity Receiving Information (Address)

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Purpose of Disclosure:

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I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable disease including HIV/AIDS this information will be included as part of my medical record to the above named person/Entity.

I understand that if the purpose for use or disclosure of my protected health information is for marketing, the Medical Group may receive direct or indirect payment in connection with the marketing.

I understand that I have the right to refuse to sign this authorization and that the Medical Group will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that for purposes of conducting independent medical exams solely for a third party, the Medical Group will not perform the exam unless I have signed an authorization to release protected heath information to the third party.

I understand that I have the right to withdraw this authorization, except to the extent that the Medical Group has already acted on the authorization, by sending a written notice addressed to: HIPAA Privacy Officer, 15 Medical Park, Suite 300, Columbia, SC 29203.

This authorization expires on the following date or event: __________________________________ (if no date indicated, one year).

____ ____________________________ __________________
Patient's Signature or Legally Qualified Representative Patient/Guardian Print Name Date/Time

____ _______________
Relation to Patient Date/Time