MACKEY FAMILY PRACTICE, P.A.
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Lancaster, South Carolina 29720

Phone 803-285-7414 **Toll Free 1-877-837-6507** **Fax 803-283-4329**

Authorization To Disclose Health Information & Release Record

1. Regarding Patient: **Email address:** ____________________

____
Last Name First Name MI

____
Street Address

____
City State Zip Code

____________ ____________ ☐ Male ☐ Female
Date of Birth Phone

2. Information Released From:

____
Name (Health Care Provider)

____
Street Address

____
City State Zip

____
Phone

3. Information Released To:

____
Name (Health Care Provider)

____
Street Address

____
City State Zip

____
Phone

4. This Information Shall Include the Following:

Date(s) of service to release: ____________________

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress/Office Notes
- ☐ Consultation
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ ECG/EEG/Cardiac Cath
- ☐ Radiology Report
- ☐ Emergency Report
- ☐ Nursing Notes
- ☐ Entire Record
- ☐ Other (Specify):____________________

5. NOTICE: This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, name of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.
Exclusions: ____________________

6. Purpose for Disclosure:

- ☐ Continuing Treatment
- ☐ Legal Investigation
- ☐ Insurance
- ☐ Disability Determination
- ☐ Worker's Compensation
- ☐ Personal
- ☐ Other (Specify):____________________

7. RESTRICTIONS: I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. I hereby authorize disclosure of the health information to the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification, but that it will not have any effect on information released prior to notification of cancellation.

Signature of Patient/Legal Authority: ____________________ **Date:** ____________

Legal Authority is: ☐ Guardian ☐ Parent of Minor ☐ Attorney in Fact ☐ Next of Kin ☐ Executor of Estate ☐ Other____________________

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Documentation of legal status must be attached.