



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

- Roper Hospital
  - Bon Secours St. Francis Hospital
  - Roper Berkeley
  - Roper St. Francis Physician Network
- is hereby granted authorization to release copies of medical records on:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date(s) of Service Requested: \_\_\_\_\_

Information Requested: \_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_

Released By: \_\_\_\_\_

Released To: \_\_\_\_\_

Address: \_\_\_\_\_

- ◆ **I understand that this information may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse and results of tests for all infectious diseases including AIDS/HIV.**
- ◆ **I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department in writing.**
- ◆ **I understand that revocation will not apply to information that has already been released in response to this authorization.**
- ◆ **I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
- ◆ **I understand that authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization.**
- ◆ **I understand that I may inspect or obtain a copy of the information to be used or disclosed.**
- ◆ **I understand that this authorization will automatically expire ninety (90) days from the date it is signed unless revoked sooner.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

Dated this \_\_\_\_\_ day of \_\_\_\_\_ (year)

**Revised: November 15, 2002  
January 7, 2008**

