CHARLESTON ENT, LLC
2295 Henry Tecklenburg Drive, Charleston, SC 29414
Phone: 843-766-7103 / Fax: 843-725-3888

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completed in its entirety in order to be considered valid.
Return completed form in person, by mail or fax with a copy of your photo I.D

Patient Name: ____________________________________ Date of Birth: ___________________________

Address: ____

Last 4 digits Social Security Number: ____________ Patient's Email Address: _______________________________________

☐ I authorize Charleston ENT, LLC to disclose/release information TO:

☐ I authorize Charleston ENT, LLC to obtain information FROM:

Name of Individual/Organization: ____

Street Address: ________________________________ City: __________________ State: _______ Zip Code: _________

Phone Number: ________________________________ Fax Number: ____________________ (cannot fax to a residence)

The purpose of the disclosure is: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request

☐ Other____ Date(s) of service: __________________________________

Information to be released (Check all that apply):

- ☐ Entire record
- ☐ Medication List
- ☐ Physician progress/Visit notes*
- ☐ Physician orders*
- ☐ Operative Reports*
- ☐ Films/ Images*
- ☐ Nurses notes*
- ☐ Laboratory Reports*
- ☐ Radiology Reports*
- ☐ Other__________________________________

For selections marked above please provide the date range that you would like to information from.

***Dates of treatment to be released**: From _____________To_______________

Patient's Rights- I understand that:

- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
  I have a right to receive a copy of this form upon request.
- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- Charleston ENT will not share or use my health information without permission other than by ways listed in Charleston ENT Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.charlestonent.com.

______________________________ ______________________________ ____________________

Printed Name | Signature of Patient or Legal Guardian/ Representative | Date

______________________________________ ______________________________

Relationship to Patient, if signed by Legal Guardian/Representative | Witness Signature

Document(s) of patient representative's authority must be attached if patient is not signing.

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Request for Medical Records

Physician / Continuing Care: (NO CHARGE)

*Records will be delivered directly to the provider specified by our facility.

*Please complete all fields to avoid any delay in delivery of your records.

Personal Copy: (FEE REQUIRED)

*Records will be delivered to the address indicated on your authorization.

*Please complete all fields to avoid any delay in delivery of your records.

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PLEASE NOTE

There is a fee for reproducing patient records.

These fees are pursuant to SC ST SEC 44-115-80 and are as follows:

*$25.00 Search and Retrieval Fee (plus per page fee below)

*$0.65 Per page for pages 1-30

*$0.50 Per page for all other pages

*Plus Actual Postage

(Maximum Fee of $150 for Electronic Delivery)

(Maximum Fee of $200 for Paper Delivery)

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We have partnered with a company called RecordQuest who will provide the safest and fastest delivery of your medical records. You will receive an invoice by Email, Fax or US Mail indicating the charges. Please follow instructions indicated on the invoice from RecordQuest for payment and delivery options.

____

Signature / Date

____

Email (Please write clearly)