Piedmont Physician Network, LLC – Family Medicine Associates
1023 Creekside Medical Drive, York, SC 29745 / 207 Church Street, Clover, SC 29710
Office: 803-684-3738 Fax: 803-684-3808 / Office: 803-222-3063 Fax: 803-222-3064

RECORD RELEASE or AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle
Home Address: _____
_____
_____

Home Telephone: _____ Date of Birth: _____
Social Security Number: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

☐ Discharge Summary	☐ Progress/Physician Notes	☐ X-Ray Report	☐ Pathology Report
☐ History & Physical	☐ Nurses Notes	☐ EKG/EMG/EEG Report	☐ Consult Report
☐ Emergency Report	☐ Laboratory Report	☐ Operative Report	☐ Entire Record
☐ Other:			

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

☐ RELEASE Information To: _____ ☐ REQUEST Information From: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Fax: _____

TERM: This Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____day of _____, 20___.
- ☐ Until Piedmont Physician Network, LLC fulfills this request.
- ☐ Until the following event occurs: _____
- ☐ Other: _____

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PURPOSE: I authorize Piedmont Physician Network, LLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

RECORD RELEASE or AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Piedmont Physician Network, LLC discloses my health information to the recipient, Piedmont Physician Network, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Piedmont Physician Network, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Piedmont Physician Network, LLC; except, however, if my treatment at Piedmont Physician Network, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Piedmont Physician Network, LLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Piedmont Physician Network, LLC's Privacy Office at the practice address. The revocation will be effective immediately upon Piedmont Physician Network, LLC's receipt of my written notice, except that the revocation will not have any effect on any action taken by Piedmont Physician Network, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact Piedmont Physician Network, LLC's Privacy Office at:

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Piedmont Physician Network, LLC to use or disclose my health information in the manner described above.

_____ _____
Signature **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Authorized Personal Representative Relationship to Patient Date