



RADIOGRAPHIC RECORDS REQUEST / AUTHORIZATION

2880 TRICOM STREET NORTH CHARLESTON SC 29406

PHONE 843-797-5050 / FAX 843-793-5402

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I AUTHORIZE LOWCOUNTRY ORTHOPAEDICS AND / OR THE BELOW LISTED PHYSICIAN / FACILITY TO RELEASE OR OBTAIN MY PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

_____ PATIENT NAME _____		_____ DOB _____	_____ CHART # _____
_____ ADDRESS _____	_____ CITY _____	_____ STATE _____	_____ ZIP CODE _____
_____ TELEPHONE NUMBER _____	_____ ALTERNATE PHONE NUMBER _____		

___ ALL X-RAY FILMS AND / OR MRI DISKS FROM DATE OF SERVICE _____ TO _____

___ SELF (NON-MEDICAL PROFESSIONAL, \$10.00 PER DISK MUST BE PRE PAID AT TIME OF REQUEST)

___ CONTINUING MEDICAL CARE (MEDICAL PROFESSIONAL , NO CHARGE)

INFORMATION REQUESTED TO BE RELEASED TO _____ OR REQUESTED FROM _____
(MUST BE COMPLETED IF REQUESTED FOR MEDICAL PROFESSIONAL)

_____ COMPANY NAME, PERSON, FACILITY OR DOCTOR NAME _____			
_____ ADDRESS _____	_____ CITY _____	_____ STATE _____	_____ ZIP CODE _____
_____ PHONE NUMBER _____	_____ FAX NUMBER _____		

I understand that information in my health record may include information relating to Sexually Transmitted Diseases (STD's), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information.

I may refuse to sign this authorization form. I understand that Lowcountry Orthopaedics will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Lowcountry Orthopaedics' Notice of Privacy explains the process for revocation, which includes a request in writing.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state and federal regulations and may be re-disclosed by the entity that receives the information. I release Lowcountry Orthopaedics, its physicians, employees and business associates from any legal responsibility or liability for the re-disclosure of information by a third party. **The patient / patient representative understands that a fee will be applied when radiographic records are released to any non-medical entity. The patient / patient representative understands that a \$ 10.00 charge per disk is due at the time of request.**

_____ PATIENT SIGNATURE _____

_____ DATE _____

Disc Burned: _____
Date Burned: _____

_____ SIGNATURE OF LEGAL REPRESENTATIVE _____

_____ RELATIONSHIP TO PATIENT OR DESCRIPTION OF AUTHORITY TO ACT FOR THE PATIENT _____

Paid Initials _____