2880 TRICOM STREET NORTH CHARLESTON SC
29406 PHONE 843-797-5050 / FAX 843-793-5402

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Physician / Continuing Care: (NO CHARGE) Records will be delivered directly to the provider specified by our facility. Personal Copy: (FEE REQUIRED) Records will be delivered to the address indicated on your authorization. PLEASE NOTE There is a fee for reproducing patient records. These fees are pursuant to SC ST SEC 44-115- 80. 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 COMPLETE ALL FIELDS TO AVOID ANY DELAY IN DELIVERY OF YOUR RECORDS.

Print Patient's Full Name: Birth Date (Mo/Day/Yr.):

Street Address: SSN#:

City, State, Zip Code: Email: Phone:

At the request of the individual, I_____, do hereby authorize LCO/Arcis to release:
(Patient's Name)

DATES OF SERVICE: _____

- ☐ DISCHARGE SUMMARY
- ☐ HISTORY & PHYSICAL
- ☐ PROGRESS NOTES
- ☐ OPERATIVE NOTES
- ☐ PATHOLOGY REPORTS
- ☐ LABORATORY REPORTS
- ☐ RADIOLOGY REPORTS
- ☐ EMERGENCY REPORTS
- ☐ OTHER

RELEASE TO: ☐
REQUEST FROM: ☐

_____
Name of Company/Agency/Facility/Person

Street Address

City, State, Zip Code

Phone:

Fax:

Email address:

PURPOSE OF DISCLOSURE:

- ☐ REFERRAL TO SPECIALIST
- ☐ DISABILITY DETERMINATION
- ☐ INSURANCE
- ☐ PERSONAL
- ☐ WORKERS COMP
- ☐ CONTINUING CARE
- ☐ CHANGE OF DOCTOR
- ☐ LEGAL INVESTIGATION

OTHER (SPECIFY):_____

Please provide a current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

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 records are released to any non-medical entity. The patient / patient representative understands LCO utilize a third-party company to process, deliver and bill for these requests. You will receive a statement from RecordsQuest, and you should remit your payment directly to them.**

_____
Signature of Individual or Guardian or Personal Representative of Patient's estate

_____
Date: