



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
_____	_____	_____
TELEPHONE NUMBER	ALTERNATE PHONE NUMBER	

___ ALL X-RAY FILMS AND / OR MRI DISKS FORM 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 my health records may contain highly sensitive information, including data relating to Sexually Transmitted Diseases (STDs), HIV/AIDS, other communicable diseases, Behavioral or Psychiatric Care, and treatment for alcohol or drug abuse; my signature specifically authorizes the release of such information. I understand that I may refuse to sign this authorization and that Lowcountry Orthopedics will not condition my treatment or eligibility for benefits on whether I sign this form. I may revoke this authorization at any time in writing, except for actions already taken in reliance on it. I acknowledge that once these radiographic images and associated records are disclosed to a third party, they may no longer be protected by federal privacy regulations and could be subject to redisclosure; I release Lowcountry Orthopedics, its physicians, and employees from any liability for such redisclosure. I understand that because digital imaging is not currently available via the patient portal, a CD must be produced to transfer these records. **I agree to pay a reasonable, cost-based fee of \$10.00 to cover the cost of the physical media and the labor required to prepare the disc. This fee is due at the time of the request.**

_____	_____	Disc Burned: _____				
PATIENT SIGNATURE	DATE	Date Burned: _____				
_____	_____	<table border="1"><tr><td><input type="checkbox"/></td><td>Initials _____</td></tr><tr><td>Paid</td><td></td></tr></table>	<input type="checkbox"/>	Initials _____	Paid	
<input type="checkbox"/>	Initials _____					
Paid						
SIGNATURE OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT OR DESCRIPTION OF AUTHORITY TO ACT FOR THE PATIENT					