AUTHORIZATION

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO MUSC ANESTHESIA PRE-OPERATIVE CLINIC

Form Origination Date: 9/2016

Patient Name:___________________________________

Date of Birth:___________________________________

Last 4 digits of SSN:_____________________________

Phone #:____

MRN (internal only):______________________________

Version: 1 Version Date: 9/2016

Obtain Records From:	**NAME/ ORGANIZATION:**___________________________________ **Attention to:** ____________________ **Address** ____ **City:**__________________________________ **State** _________ **Zip code:** ______________________ **Day Phone Number:** ___________________________ **Fax Number** ______________________________
Release Instructions:	**RELEASE METHOD / FORMAT REQUESTED:** ☐ **PLEASE FAX REQUESTED INFORMATION TO THE MUSC ANESTHESIA PRE-OPERATIVE CLINIC.** **FAX # 843-876-0108. PHONE #: 843-876-0116. ATTN:** ______________________________
Purpose of Release:	☐ **PREOPERATIVE ANESTHESIA CLEARANCE FOR PROCEDURE** ***UNLESS CANCELLED OR REVOKED THIS AUTHORIZATION WILL EXPIRE THREE MONTHS FROM THE DATE NOTED BELOW.**
Information to be Released:	☐ Physician clinic/progress notes ☐ Echocardiogram report ☐ Cardiac catheterization report ☐ Stress test ☐ EKG ☐ Pacemaker/ICD interrogation report ☐ Pulmonary function testing ☐ Anesthesia record ☐ Discharge summary ☐ Admission H&P ☐ Other: ______________________________

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date or ____________.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information.

______________________________________ ______________________________

Printed Name of Patient or Legal Guardian / Representative Date

X______________________________________

Signature of Patient or Legal Guardian/Representative

______________________________________ ______________________________

Relationship to Patient, if signed by Legal Guardian Witness Signature

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

To contact MUSC Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 /Suite 200/ Attention: Release of Information / Charleston, South Carolina 29425-3490; the phone number is (843) 792-3881; FAX NUMBER 843-876-8080 or 843-876-8055.

Original to medical record **Copy to patient**