Hilton Head Regional Healthcare

FOR INTERNAL USE ONLY

PATIENT ACCOUNT NUMBER _____

☐ COMPLETE ☐ INITIALS _____ ☐ DATE _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: Date of Birth: Phone #:

Address:

Company Name: Physician:

Attention:

Phone: Fax:

I hereby give permission for my actual imaging films (CDs preferred) to be transferred to:
Hilton Head Hospital's Bluffton Medical Campus
Imaging Services
75 Baylor Drive, Suite 125, Bluffton, SC 29910
Telephone: (843) 836-1640
Fax: (843) 705-7031
Please send all breast related studies.

Highly Confidential Information

By checking any of the items below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated. (This is for patients who want to limit the type of information that is disclosed to a third party. Placing a check-mark next to the item indicates that it is okay to send that information to the third party.)

- ☐ Information about a mental health or mental retardation service
- ☐ Psychotherapy notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that a test was ordered)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse
- ☐ ALL – It is OK to send any and all requested information

Term

This authorization will remain in effect:

- ☐ From the date of this authorization until the _____ day of _____ , 20 _____
- ☐ Until the following event occurs: _____
- ☐ Until Hilton Head Hospital fulfills this request.
- ☐ Other: _____

Purpose

I authorize Hilton Head Hospital to use and 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): _____

I understand that once Hilton Head Hospital ("HHH") discloses the information to the designated recipient, HHH cannot guarantee that the recipient will not redisclose the information to a third party. The third party may not be required to abide by the Authorization or any applicable federal or state law governing the use and disclosure of my health information.

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

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

I understand that this authorization will remain in effect until the term indicated expires or I have provided written notice o revocation to HHH's Privacy Officer at the address listed below. The revocation will be effective immediately upon HHH's receipt of my written notice, expect that the revocation will not have any effect of any action taken by HHH in reliance on this authorization before it received written notice of revocation.

For questions about my rights under HIPAA I may contact HHH's Privacy Officer by phone at (843) 689-8189, or by email at hhh-privacy@tenethealth.com, or by mail at 25 Hospital Center Blvd., Hilton head Island, SC 29926.

For all other questions relating to this Authorization and medical Record Requests, I may contact HHH Release of Information by phone at (843) 689-8491 or (843) 689-8305, or by mail at 25 Hospital Center Blvd., Hilton Head Island, SC 29926.

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

Continuity of Care

Signature of Patient (or Legal Representative) Relationship Date

Signature of Employee Type of Identification