Mayes Internal Medicine, LLC

35 Bill Fries Drive, BLDG L, Hilton Head SC 29926 (P) 843-342-4455 (F)843-342-4456

Authorization for Use or Disclosure of Protected Health Information

The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164.

Patient Name _____

Date of Birth _____ Last 4 of SSN_____

I authorize the use or disclosure of the above-named individual's health information, as described below (check off the appropriate item(s), and include other information, where indicated):

❑ Discharge summary ❑ Lab results ❑ Consults

❑ History and physical ❑ Radiology reports ❑ O.R reports ❑ Entire record

❑ Other:_____

This information is being disclosed for the following purpose(s):_____

The following individuals or organizations are authorized to make the disclosure/receive my medical information:

❑ TO: ❑ FROM:

Mayes Internal Medicine
35 Bill Fries Drive, BLDG L
Hilton Head, SC 29926
(P)843-342-4455
(F)843-342-4456

❑ TO: ❑ FROM:

Name _____
Address _____
_____
(P)_____
(F)_____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse
- 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 or state regulations.
- I understand the information obtained through this release will be used for medical treatment, payment, enrollment in health plan, or eligibility for benefits.
- I understand that refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I may revoke this authorization anytime by notifying **Mayes Internal Medicine** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event, or condition, this authorization will expire twelve months from the date of signing.

Signature of Patient or Legal Representative _____ Date_____

* If signed by legal representative, relationship to patient_____

Signature of Witness _____ Date_____