AUTHORIZATION TO RELEASE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize ____
to disclose or release any/all information as may be requested to:

Rhoad & Rhoad, Attorneys at Law, 123 W. Main Street, Moncks Corner, SC 29461
Phone No. (843) 482-8877 Fax No. (843) 482-2852

I authorize the exchange of this information via: ☐mail ☐fax ☐e-mail ☐phone ☐all
(A photocopy or faxed copy of this Authorization may be accepted)

PATIENT'S NAME: ____

DOB: ________________ SS#: ________________

Date of Service Requested: From: ________________ To: ________________

Information Requested: ( ) MEDICAL RECORDS ( ) INVOICES

Purpose of Disclosure: Client - Attorney - Legal Review/Reference

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

* I understand that I have the right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke by notifying the Medical Records Department in writing. I understand that the cancellation/revocation will not apply to information that has already been released in response to this authorization. Unless otherwise canceled/revoked, this authorization will expire/end one year from the date signed below.

* I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

* I understand that authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization. I understand that I may review and/or copy the information to be disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person organization receiving information.

* I understand that I will be given a copy of this authorization.

____
Witness Signature

Date: ______________________________

____
Signature of Patient or Legal Guardian

____
Printed Name of Patient or Legal Guardian
Date:
____