Lowcountry Psychiatric Associates
25 Clark Summit Dr F-201
Bluffton SC 29910

HIPAA Privacy - Release of Information Authorization Form

Patient Name _____ DOB: _____

Address _____City_____State_____Zip_____

****1. Authorization**** I authorize the following provider(s):
□ **Joseph Walters** □ **Richard Ford** □ **Suzanne Veilleux** □ **Marianne Osentoski**
□ **Vicki Bonnell and/or** □ **All Providers** to **request and/or release** the disclosure of the protected health information described below **to and/or from** the following individuals/organizations:

Name of Person/Practice/Organization:_____

Address: _____City_____State_____Zip_____

Phone #:_____Fax #:_____

Name of Person/Practice/Organization:_____

Address: _____City_____State_____Zip_____

Phone #:_____Fax #:_____

****2. Effective Period**** This authorization for release of information covers the period of healthcare **from this date forward** unless I revoke the authorization in writing.

****3. Extent of Authorization****
□ I authorize the release of my ***complete*** health record (including recordsrelating to mental healthcare, communicable disease, and treatment of alcohol or drug abuse).

****OR****

I authorize the release of my complete health record with the ***exception*** of the following information:

□ **Mental health records**
□ **Communicable diseases (including HIV and AIDS)**
□ **Alcohol/drug abuse treatment**
□ **Other (please specify):** _____

I understand that my records are protected by the Federal Confidentiality Regulations as well as the provisions of HIPPA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian Signature _____DATE_____

Printed name of Patient/Guardian_____