



HIPAA RELEASE/Authorization

This authorization form permits:

Name: Charleston Cancer Center

Address: 2910 Tricom Street

City/State/ Zip: North Charleston, SC 29406

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____
 Address _____
 City/State/ Zip _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice mail # _____	<input type="checkbox"/> Appointment time <input type="checkbox"/> Results of lab test or x-rays <input type="checkbox"/> Other _____
Employer	<input type="checkbox"/> Appointment or absentee information <input type="checkbox"/> Return to work or school information
Spouse (Provide name) _____	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial information <input type="checkbox"/> Medical information- please list _____
Parent (Provide name) _____	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial information <input type="checkbox"/> Medical information- please list _____
Other (Provide name) _____	<input type="checkbox"/> Financial information <input type="checkbox"/> Medical information- please list _____
Relationship _____	
Other (Provide name) _____	<input type="checkbox"/> Financial information <input type="checkbox"/> Medical information- please list _____
Relationship _____	

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

(Continued on back)

Expiration date or event: This authorization shall be enforced until revoked by the patient.

Verification method or code: This practice will verify the identity of any entity requesting protected health information.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

Office Use Only:

Receiving Employee _____ Date received _____

Copy given to patient