

# Lowcountry Psychiatric Associates

25 Clark Summit Dr F201

Bluffton SC 29910

Office 843-757-4737 Fax 843-757-4585

## Authorization to Release Medical Information

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Authorization** I authorize the following provider(s):

**Joseph Walters**    **Richard Ford**    **Leah Carter-Lafountain**    **Vicki Bonnell**

to request and/or release the disclosure of the protected health information to/from the following individuals/organizations:

**1.) Name of Relative/Practice/Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**2.) Name of Relative/Practice/Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ Office Notes

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ Radiology Reports

\_\_\_\_\_ History & Physical

\_\_\_\_\_ Operative Reports

\_\_\_\_\_ Consultation Reports

\_\_\_\_\_ Other: \_\_\_\_\_

### **Please forward copies to:**

Lowcountry Psychiatric Associates  
25 Clark Summit Dr Ste F201  
Bluffton SC 29910

or

Fax: 843-757-4585

Email: lowcountrypa@gmail.com

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** \_\_\_\_\_