

# Emmaus Med/Surg Clinic

\*Retain Original and Provide Patient with a copy

MR#/SSN: \_\_\_\_\_

## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Emmaus Med/Surg Clinic to use or disclose my protected health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: \_\_\_\_\_ SSN : \_\_\_\_\_

Street: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of person/facility authorized to RELEASE the information: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of person/facility authorized to RECEIVE the information:

Bert B. Oubre, M.D., F.A.C.S.  
Emmaus Med/Surg Clinic  
669 Barr Road  
Lexington, SC 29072  
Phone 803-359-0164  
Fax 803-359-0255

Purpose of disclosure: \_\_\_\_\_ Dates of treatment: \_\_\_\_\_

Information to be used/disclosed—please check those that apply:

History and Physical  Discharge Summary  Operative Report  Other (specify) \_\_\_\_\_

Progress Notes  Laboratory Report  Radiology Report  Immunization Record

Billing Summary  Consultation Report  Pathology Report  Entire Medical Record

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, or communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

Emmaus Med/Surg Clinic may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

This authorization will automatically expire in 90 days unless otherwise stated. Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legally Qualified Representative

\_\_\_\_\_  
Date