For office use only:
X- Ray Dept - Ext 141

RADIOGRAPHIC RECORDS REQUEST / AUTHORIZATION

2880 TRICOM STREET NORTH CHARLESTON SC 29406
PHONE 843-797-5050 / FAX 843-793-5402

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
I AUTHORIZE LOWCOUNTRY ORTHOPAEDICS AND / OR THE BELOW LISTED PHYSICIAN / FACILITY TO RELEASE OR OBTAIN MY PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

_____ _____ _____
PATIENT NAME DOB CHART #

_____
ADDRESS CITY STATE ZIP CODE

_____ _____
TELEPHONE NUMBER ALTERNATE PHONE NUMBER

___ ALL **X-RAY FILMS AND / OR MRI DISKS** FORM DATE OF SERVICE _____ TO _____

___SELF (**NON-MEDICAL PROFESSIONAL , $10.00 PER DISK MUST BE PRE PAID AT TIME OF REQUEST)**

___CONTINUING MEDICAL CARE **(MEDICAL PROFESSIONAL , NO CHARGE)**

INFORMATION REQUSTED TO BE RELEASED TO:
(MUST BE COMPLETED IF REQUESTED FOR MEDICAL PROFESSIONAL)

_____
COMPANY NAME, PERSON, FACILITY OR DOCTOR NAME

_____
ADDRESS CITY STATE ZIP CODE

_____ _____
PHONE NUMBER FAX NUMBER

I understand that information in my health record may include information relating to Sexually Transmitted Diseases (STD's), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information.

I may refuse to sign this authorization form. I understand that Lowcountry Orthopaedics will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Lowcountry Orthopaedics' Notice of Privacy explains the process for revocation, which includes a request in writing.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state and federal regulations and may be re-disclosed by the entity that receives the information. I release Lowcountry Orthopaedics, its physicians, employees and business associates from any legal responsibility or liability for the re-disclosure of information by a third party. **The patient / patient representative understands that a fee will be applied when radiographic records are released to any non-medical entity. The patient / patient representative understands that a $ 10.00 charge per film is due at the time of request.**

_____ _____
PATIENT SIGNATURE DATE

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT OR DESCRIPTION OF AUTHORITY TO ACT FOR THE PATIENT

Disc Burned: _____
Date Burned: _____

Paid ☐ Initials _____