HouseCalls-MD Authorization for Release of Protected Health Information

I hereby authorize HouseCalls-MD to disclose Protected Health Information (HPI) as deemed below.

Patient: Requestor (If other than Patient): Name: _______________________________

Name: ___________________________ SSN #: ________________________________
Relationship:______________________ Date of Birth: _________________________

Source of Legal Authority: __________ _________________________________

Name and Address of who to receive health records/information:

HouseCalls-MD 8983 University Blvd #104-334 N. Charleston, SC 29406

Phone # 843-501-2031 Fax # 888-453-0810

___ I wish to have the following records copied, and I will pick them up at your facility

___ I request the facility copy the following records and fax/send them to the above address

I request the release of all medical record created between: Date: __________and__________

Legal Authority Request:

___ I am the Patient noted above

___ I am the Patient's legal representative

___ I am the Patient's Power of Attorney

___ I am the Patient's legal Guardian Requestor's Initials ___________

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

If signing as a POA, please include a copy of documentation, as some providers will not release records without additional documentation.

Signature: ____
Date:________________

Relationship to
Patient:____

Name of Person Completing this
Form:____