CHARLESTON
CANCER CENTER
Dedicated to Your Tomorrow
2910 Tricom St. North Charleston, SC 29406

HIPAA RELEASE/Authorization

This patient (or authorized person) signed form authorizes the Charleston Cancer Center to obtain, use, or disclose Protected Health Information (PHI) in the course of providing patient health care.

PHI may include any medical records such as: Lab, X-ray, PET, CT, MRI, etc. results; personal medical history, physician notes and correspondence, Power of Attorney, Living Will, medication lists, hospital or assisted facility records, and the like.

NAME of patient (print): _____ BIRTH DATE: _____

Write in names of ONLY the people you want to receive your health information

NAME :_____

NAME :_____

NAME:_____

Name: _____

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 re-disclosure by the recipient and may no longer be protected by federal or state law.

X_____Date _____

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

Personal Representative MUST provide copy of authority (Power of Attorney, Trust, Living Will, etc.)