MD First
Primary & Urgent Care

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Pt's Name: _____Date of Birth: _____

Previous Name: _____Last 4 digits of SS # : _____

I request and authorize release of records from _____

_____to

MD First Primary & Urgent Care
1130 Hwy 9 Bypass, Lancaster, SC 29720
Phone: 803-283-2300; Fax: 803-392-4550

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ ALL healthcare information

☐ Other: _____

I understand that the information in my medical record may include information relating to treatment of drug abuse, psychological or psychiatric impairment, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) AIDS related complex (ARC) and/ or human immunodeficiency virus (HIV)

Patient Signature: _____Date: _____

I understand that I have the rights to revoke this authorization at any time by notifying the Medical Record Department of the above organization in writing. I understand the revocation will not apply to information that has already been release in response to this authorization. I understand that revocation will not apply to insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information to be used or disclosed per MDFirst Primary & Urgent Care notice of Privacy policy.

This authorization will expire when the information from the event/purpose noted above is released to the MDFirst Primary & Urgent Care. If the patient is a minor or is dinically unable to sign, an authorization may be signed by Parent or Legal Guardian.

Patient Signature: _____ Date: _____