118 S.Pendelton St Easley, SC 29640 Office (864)306-4599 Fax (864)306-4597

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
HITECH MEDICAL RECORDS REQUEST

_____
Date

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

UNDER **THE HITECH ACT**, I _____, am requesting an **electronic copy** of my records. I hereby authorize,
Office: _____,
Address: _____,
Phone: _____ Fax #:_____,
to disclose information from the above-named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of **transfer of care**. I understand that this authorization will expire in 6 months, and that it may be revoked at any time in writing. I further understand that continued treatment of the above-named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rule. Either CD or jump drive may be mailed or **the preferred method of email to the address listed below**.

Please send the requested information to:

VERITY PRIMARY MEDICINE & LIFESTYLE
118 South Pendleton Street, Suite A
Easley, SC 29640
Phone: (864) 306-4599
Fax: (864) 306-4597
Email: **Contact@veritymedicine.com**

_____ _____
Signature of Patient or Legal Guardian Relationship