SOUTH CUMBERLAND MEDICAL ASSOCIATES

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856-451-4414 Fax: 856-451-2052
southcumberlandmedical.com
Christopher Ballas, MD, MBE Lori Talbot, MD

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth: _____ Soc Security #: _____

Address (street, city, state, zip) _____

Telephone Number: _____

❑ South Cumberland Medical Associates is authorized to release my protected health information as indicated below to:

X _____

❑ I hereby authorize _____ to release my protected health information to:

South Cumberland Medical Associates as indicated below.
Via Fax: (856) 451-2052, ATTN: ❑ Dr. Ballas; ❑ Dr. Talbot;

Treatment Date(s): _____

Purpose of Request: Dr/Patient Request. ❑ E.R. Visit ❑ Hospital Inpatient:

The following information is to be disclosed/released (Please check one box for each item):

❑ Physician Notes (last 6 months/6 office visits)
❑ Lab Results
❑ X-Ray Reports
❑ MRI Scans; Type:_____
❑ Other: Any medical records for follow up care:

❑ Complete Record
❑ Immunization Record
❑ Discharge Summary
❑ Cardiac Studies

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right To Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released.

Other Rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration:
❑ Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
❑ This authorization will have NO Expiration Date.

(If I do not specify an expiration date, event or condition, this authorization will expire in six (6) months).

Signature of Patient or **Legal Representative: _____ Date: _____

** If signed by Legal Representative, relationship to Patient: _____