Curtis Haskins, MD
curtishaskinsmd.com

6650 Rivers Avenue
North Charleston, SC 29406

Phone: 843-494-2411
843-576-5417
Fax: 843-410-2790

AUTHORIZATION FOR RELEASE OF INFORMATION / PRIVACY POLICY

Patient Name:_____ DOB: _____

Curtis Haskins, MD is authorized to release protected health information (PHI) to include: lab results, x-ray results, appointments, referrals, and diagnosis and treatment options about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of Information to be released.** Check each that can be given to person/entity on the left in the same section.
❒Voice Mail	❒ Lab results ❒ X-ray results ❒ Appointments ❒ Referrals ❒ Diagnosis and treatment options
❒ Spouse (provide name & phone number)	❒ Lab results ❒ X-ray results ❒ Appointments ❒ Referrals ❒ Diagnosis and treatment options
❒ Parent (provide name and phone number)	❒ Lab results ❒ X-ray results ❒ Appointments ❒ Referrals ❒ Diagnosis and treatment options
❒ Other (provide name and phone number)	❒ Lab results ❒ X-ray results ❒ Appointments ❒ Referrals ❒ Diagnosis and treatment options

Email and Voice Mail Messages

I understand that if I choose to communicate personal health information by email to or from Curtis Haskins, MD, I must accept any risk associated with that action, and I will NOT hold Curtis Haskins, MD or its staff responsible for any disclosure of that information. I also understand that:

- Email is a convenience and not appropriate for emergencies or time-sensitive issues.
- Email may not be reviewed every day.
- No one can guarantee the privacy of email messages. Email transmitted to or from a patient will NOT be encrypted.
- Highly sensitive or personal information should not be communicated via email.

Email Address: _____

Patient/Legal Guardian Signature _____Date _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

Date: _____

_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)