Palmetto INFUSION

HIPAA RELEASE OF PROTECTED INFORMATION CONSENT FORM

I hereby authorize **Palmetto Infusion Services** to use and/or disclose my Protected Health Information to person(s) or organization(s) I have specified below:

Patient Name: _____ **MRN:** _____

Name	**Relationship**	**Contact Information**

☐ Disclose my complete health information including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

☐ I hereby authorize the release of my health information with the following exclusions:

I understand that I may revoke this authorization at any time and can do so by submitting a written request to:

HIPAA Compliance Officer
Palmetto Infusion Services
3105 Sunset Blvd
West Columbia, SC 29169

If I decide to revoke this authorization I understand that my health information may have been shared with persons and organizations prior to the date of my revocation.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name **Date**

_____
Print Name of Patient or Legal Guardian, if applicable