AUTHRELSE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION –

DONOR COMPATIBILITY

This form must be completed in its entirety in order to be considered valid.

Patient Name: ______________________ Date of Birth: ______________________

Medical Record Number: ______________________ Last 4 digits Social Security Number: ____________

☑ I authorize MUSC Medical Center to disclose / release information to:
☐ I authorize MUSC Medical Center to obtain information from:

Name of Individual / Organization: Recipient

Street Address: ____________ City: ____________ State: ______ Zip Code: ______

Phone Number: ____________ Fax Number: ____________ E-mail Address: ____________

The purpose of the disclosure is to assure compatability between the recipient and donor organs. My medical record number, unique Donor Identification number, and vital data required to validate / verify my blood type and other necessary clinical information will be listed on the Blood Typing verification form.

Date(s) of service: ______________________

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice or information that may be included as part of the recipient's medical record. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date or ______________________.

I understand that fees for copies of medical records and postage fees may be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization.

______________________ ______________________
Signature of Patient or Legal Guardian / Representative Date

____
Printed Name of Patient or Legal Guardian / Representative

______________________ ______________________
Relationship to Patient, if signed by Legal Guardian / Representative Witness Signature

Description of patient representative's authority: ______________________
(The reason the patient is not signing)

To contact Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 / Attention: Release of Information / Charleston, South Carolina 29425-3490; the phone number is (843) 792-3881.

Original to medical record Copy to patient