



Patient:

DOB:

SSN:

I, _____, hereby authorize Access Healthcare, LLC to obtain a copy of my **complete medical record** from the following health care provider(s) and authorize these health care provider(s) to disclose the following protected health information to Access Healthcare:

Name of Facility/Provider

Phone Number / Fax Number

Name of Facility/Provider

Phone Number / Fax Number

Name of Facility/Provider

Phone Number / Fax Number

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Access Healthcare in the following manner: archived as reference to facilitate medical treatment performed by Access Healthcare and its representatives.

This authorization shall be in force and effect for 365 days or until so revoked by me in writing to Access Healthcare at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 235 Calhoun Street, Charleston, SC 29401 or at www.Access-HIPAA@letssimplify.com. I understand that a revocation is not effective to the extent that Access Healthcare has relied on the use or disclosure of the protected health information.

Access Healthcare will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Patient Signature

Date

Personal Representative

Description of Representative

Please select a location:

Dr. David Albenberg
235 Calhoun Street
Charleston, SC 29401
T 843.853.8870
F 843.853.8737

Dr. Jennifer Pullano
246 Mathis Ferry Road, Suite 100
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T 843.971.9900
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