Authorization to Release Healthcare Information

Patient's Name: ______________________ Date of Birth: __________________

Previous Names: _____________________ Social Security #: ____________________

Medicare ID#: _______________________

I request and authorize ALL PREVIOUS HEALTHCARE PROVIDERS to release healthcare information of the patient named above to:

Greer Office

955 W. Wade Hampton Blvd. Suite 3A

Greer, SC 29650

864-326-3242

fax: 864-326-3433

Anderson Office

1801 North Main Street Suite B

Anderson SC 29621

864-642-1279

fax: 864-642-0534

This request applies to the following:

- Protected Healthcare Information (PHI) relating to the following treatment, condition dates:

  ____

  ____
- All Protected Healthcare Information (PHI)
- Other: ____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release Statement:

I understand that it is my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B or C testing, HIV/AIDS testing/treatment, and/or other sensitive information, I agree to its release.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I can inspect or copy the Protected Health Information (PHI) to be used or disclosed. I authorize Wren Hospice to use and disclose the PHI specified above.

________________________________ ________________________________

Patient Signature Date Person Authorized to Sign Date