



Dear Patient:

Thank you for contacting **Lowcountry Urology Clinics** Medical Records Department. To better serve you with your request for medical records, **Lowcountry Urology Clinics** has partnered with Sharecare.

Sharecare will fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting records to be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. *The fax delivery option may only be used for records going to a doctor. Please mail/fax/drop-off the completed Authorization form to Lowcountry Urology Clinics.*

If you choose to fax your request, please fax to **(843) 766-3399**. Please include a copy of your Driver's License.

If you choose to mail request, please send to:

Lowcountry Urology Clinics
Attention: Medical Records
641 Saint Andrews Blvd.
Charleston, SC 29407

For Records being sent to another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling:

858-244-1811

Thank you,

Medical Records Supervisor
Lowcountry Urology Clinics





Authorization to Disclose Protected Health Information
The undersigned authorizes

Low Country Urology Clinics
641 Saint Andrews Blvd Charleston, SC 29407
(P) (843) 766-9747 (F) (843) 766-3399

to release my health information as noted below:

Patient Information

Patient Full Name: Other Names?

Patient Address: Date of Birth:

City: State: Zip: Phone #:

Release Information To

Email address for record delivery: Please ensure email address is legible!

Grid for email address input

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Name/Facility: Attention:

Address: Phone:

City: State: Zip: Fax #:

Purpose of Request: Personal Treatment Legal Insurance Transfer Other:

Information to be Released

If you fail to specify, a 1-year abstract will be provided.

Please release a 1-year abstract of my records (includes most recent notes, labs, procedures & testing)

Please release a 2-year abstract of my records (office notes, labs, procedures & testing, up to 2 years)

Date Range:

- Progress Notes Radiology Reports Labs
Operative Reports Injections Physical Therapy
Other:

(Please pick ONE delivery option)

- Send by Email Fax to Doctor Records on Paper
Records on CD

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed South Carolina Statute: (44-7-325)

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * (Please Initial)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I do not specify expiration this authorization will expire in 90 days. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released; we may be unable to fulfill this request.

Signature*: Date:

* For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.