South Carolina Authorization to Release Health Information

Return address

1. I request ______________________________ to complete this form for me. ______________________________
   (Person's name that completes the form) *(Signature of patient/personal representative)*
2. I ________________________authorize _ to allow ________________________ to accompany me during my appointment on ______________________________, and I understand that protected health information may be discussed during this appointment.
3. I ______________________________authorize ______________________________to disclose the following protected health information from the medical records of ______________________________ ____________ to__________________________.
   Name of Patient *Date of Birth*

Patient Initials All That Apply. (Checking "ALL" under a services type includes labs results for that service type.)

Service Type	**Initials**	**All**	**Specific**	**Service Type**	**Initials**	**All**	**Specific**
Alcohol/Other Substance Abuse				Mental Health			
CSHCN				Newborn Home Visit			
Family Planning				Nurse Family Partnership			
HIV/AIDS				STD			
Home Health				TB			
Immunizations				WIC			
Lab/Diagnostic Tests				Other			

I do NOT want the following information released:
____/__________. (Patient's initials)

4. Purpose for the release of information: (Patient initials **one**) __________continuation of treatment; or __________ personal copy; or_________ legal; or Other (Enter purpose for release and initial)______________________________
5. This authorization is effective until: (Patient initials **one**) _______One year from today; or ________ Until discharged from Program; or Other (Patient enters specific date or event and initials)______________________________
   I understand that a copy of this authorization may be treated as an original.
6. You may release my protected health information to the person or entity named in #3 above in the following ways:
   a) By fax _______(Patient initials here) Fax number ______________________________
   b) By e-mail ______(Patient initials here) E-mail address ______________________________
   c) By mail_____(Patient initials here) Mailing Address______________________________.
   I understand that my confidentiality cannot be guaranteed by sending my information by these methods.
7. ______________________________ ________ ______________________________ ________
   Signature of Patient or Personal Representative Date Witness - **ONLY** if patient cannot sign or signs with an "X" Date

   ______________________________ ______________________________
   (Printed Name of Patient) Relationship of Personal Representative (if signed by personal representative) I understand that I may ask to see or receive a copy of my information before it is released. I understand that the information disclosed at my request may be re-disclosed by the person that receives it and may no longer be protected by state or federal law. I understand that the individual or organization may not condition treatment, enrollment or eligibility for benefits if I refuse to sign this authorization; however, I understand that I may not be eligible for services from some programs if I refuse to allow the release of information needed for treatment, payment, enrollment or eligibility for benefits.

Copy of this form Provided to Patient ☐ **or Copy Declined** ☐ **or Copy Mailed to Patient** ☐

8. Revoking This Authorization: I understand that I may revoke this authorization at any time by signing below, except when information has already been released in reliance on this authorization or to obtain insurance benefits.

   ______________________________(Patient/authorized representative) Date:______________
   ______________________________(Witness: Required if patient cannot sign or signs with "x") Date:______________

(Patient label may be used here)

Patient's Name: ______________________________
Date of Birth: ______________________________

Information Released to:	Information Released/Signature/Date:
1. Name: ______	1. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
2. Name: ______	2. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
3. Name: ______	3. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
4. Name: ______	4. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
5. Name: ______	5. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
6. Name: ______	6. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
7. Name: ______	7. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
8. Name: ______	8. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
9. Name: ______	9. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______
10. Name: ______	10. ______
Address: ______	______
City/State/Zip Code: ______	______
Other: ______	______

(Patient label may be used here)

Patient’s Health Record Number: ______
Patient’s Name: ______
Date of Birth: ______