SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Authorization to Disclose SCDMH Protected Health Information

I, _____ , at _____
Name of Patient — Address (Street, City, State, Zip)

Date of Birth: _____ SSN: _____

Authorize the release of my SCDMH health information, as specified below, for the following purpose: _____

I authorize the release of the following information for the time period from: _____ to _____

Information from (name of specific Mental Health Center(s), SCDMH Hospital(s), SCDMH Nursing Facility(ies) or SCDMH Program(s)):

_____

_____

_____

And the information authorized to be released includes:

- ☐ Clinical Assessment
- ☐ Clinical Service Notes / Progress Notes
- ☐ Admission and Discharge Dates, Diagnosis (Face Sheet)
- ☐ Treatment Plan (Plan of Care)
- ☐ Discharge Summary (Summary of Treatment)
- ☐ Medication / Physician's Medication Orders
- ☐ History and Physical
- ☐ Psychiatric Evaluation (PMA)
- ☐ Billing and Payment Information
- ☐ Alcohol and Drug Information
- ☐ Written Summary (copy attached)
- ☐ Progress Summaries
- ☐ HIV Information
- ☐ Continuity of Care Clinical Data
- ☐ Other (specify): _____

This information should be released to:

Name: _____

Address: _____

_____

_____

Telephone No.: _____

Fax Number: _____

Relationship: _____

_____

_____

_____

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

_____

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

_____

I understand that information disclosed may be subject to re-disclosure by the entity name above. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization.

_____ _____ _____
Signature of Patient / Personal Representative — Printed Name — Date

Authority if signed by Personal Representative: _____

_____ _____ _____ _____
Signature of SCDMH Staff Releasing Information — Printed Name — Method of Release — Date Released

REVOCATION STATEMENT

I understand that I may revoke this authorization at any time, and will be asked to sign the revocation statement on this form in order to rescind this authorization. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization.

"I do hereby request that this authorization to disclose health information be Rescinded"

_____ _____ _____ _____
Effective Date — Signature — Printed Name — Date

_____ _____ _____
Witness Signature — Printed Name — Date