AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, ________________________________, address ____

date of birth _______________, SS#______________, medical record #______________authorize the release of my SCDMH health information, as specified below to ____

____

for the following purpose: ____

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

☐ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information only from ____

AND The information authorized to be released includes:

☐ All information from above

☐ Clinical History & Evaluation

☐ Individualized Treatment Plan Progress Summaries

☐ Physician's Medication Orders

☐ Psychiatric History and Mental Status Examination

☐ Billing and Payment Information

☐ Diagnoses

☐ Admission and Discharge Dates

☐ Discharge Summary (Summary of Treatment)

☐ History and Physical

☐ Consultant Notes

☐ Written summary (copy attached)

Other:____

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 named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. 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. I have been given a copy of this Authorization.

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Signature of Individual/Personal Representative   Printed Name   Date

Authority if signed by Personal Representative____

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Signature of DMH Staff releasing information   Printed Name   Method of Release   Date Released

SCDMH FORM
DEC. 99 (REV. MAR. 03) **M-450D**
MH-FCC-2