

Authorization for Use & Disclosure of Protected Health Information

Patient Name: _____ DOB: _____ SSN: _____

I hereby authorize Palmetto Lowcountry Behavioral Health to (check one or both) **Disclose to** and/or **Obtain Protected Health Information from:**

Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Records not routinely faxed except for necessary medical care.

Purpose of Disclosure: Continuing Care/Treatment Family/Friend Involvement in Treatment Legal Representation Payment
 Educational Placement Other _____

Relationship of Patient to Individual Receiving Information: _____

Dates of Service: All dates of service at PLBH or ONLY the following dates of service: _____

The protected information to be used/disclosed includes (check all that apply):

Oral (during treatment):

Patient ID # Contact & Demographics for Aftercare Aftercare/Discharge Plan Medical Conditions/Treatment
 Diagnosis Lab Results Other: _____

Written Documents (after treatment conclusion or for continuity of care purposes):

Psychiatric Evaluation Physician Progress Notes
 History & Physical Exam Nursing Progress Notes
 Lab Reports Social Progress Notes
 Treatment Plan Aftercare/Discharge Plan
 Consults Discharge Summary
 Nursing Assessment Medical Administration Records (MARs)
 Psychosocial Assessment Other: _____

*Fees will be charged in accordance with applicable law. Fees are charged per page. (Exception: Records released for treatment, payment, or healthcare operations.)
Payment must be received prior to release of records when payment is required.*

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws (45 CFR parts 160, 164; 42 CFR part 2; 42 USC 20 odd-3; 42 USC 290ee; SC Code Ann Section 19-11-95) and cannot be re-disclosed without my further written consent unless provided for by state and federal law.

I understand that any disclosed information has the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. I understand that my refusal to sign this authorization in no way jeopardizes my right to obtain present or future treatment or services.

EXPIRATION AND REVOCATION

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken or is otherwise authorized by law, as stated in the Privacy Notice. **If not previously revoked, this consent will expire one hundred eighty (180) days from date of signature unless another expiration date is noted here.** Instead of the above automatic expiration date, this release shall expire on ____/____/____.

DATE: _____ TIME: _____

Signature of Patient

DATE: _____ TIME: _____

Signature of Parent/Legal Guardian / Relationship to Patient *(Legal Guardian must provide proof of guardianship)*

DATE: _____ TIME: _____

Signature of Witness

GENERAL