PALMETTO LOWCOUNTRY BEHAVIORAL HEALTH

DO NOT LABEL THIS FORM

2777 Speissegger Drive Charleston, SC 29405 Phone: (843)747-5830 Fax: (843)745-5181 PALMETTOLOWMR@uhsinc.com

Authorization for Use & Disclosure of Protected Health Information

Patient Name: ______________________________ DOB: ______________ SSN: ________________

IF RELEASE FOR FAMILY/FRIEND: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ☐ IF YES, COMPLETE RELEASE BELOW TO NOTE WHOM. ☐ NO ___________(Patient initials)

You may revoke or modify this authorization with regard to any family member/other individual designated in the authorization. Revocation and/or modification must be in writing.

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 ☐Removal of lethal means of harm confirmation ☐ Other:______________________

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

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

____ DATE: ______________TIME:__________

Signature of Witness

RELEASE OF INFORMATION