7182 WOODROW STREET, # 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111
FAX: (803) 749-0050

Authorization for the Use and Disclosure of Protected Health Information

**** TO ENSURE RECORDS ARE RELEASED IN A TIMELY MANNER, THE FOLLOWING MUST BE COMPLETED ENTIRELY.****

Patient Name (at time of treatment): ______________________________

Date of Birth: ________________ **Telephone #:** ________________ **SCIM Provider Name:** ________________

Requesting information FROM: ______________________________

Address: ______________________________ **Telephone #:** ________________ **Fax #:** ________________

SEND information TO: ______________________________

Address: ______________________________ **Telephone #:** ________________

☐ Mail ☐ Pick-up ☒ Fax (____________________) ☐ Electronic *ONLY includes: Recent Lab Results, Problem List, Medication List and Allergy List

☐ E-mail (not password protected): ______________________________

☐ USB (Additional costs will apply)

Information REQUESTED: (Check all that apply)

- ☐ Patient Identification/Diagnoses list
- ☐ Health Summary
- ☐ Office notes/physician dictation
- ☐ Labs/Pathology
- ☐ EKG/Cardiovascular
- ☐ Radiology reports
- ☐ Itemized Bill
- ☐ All of the above
- ☐ Other: ______________________________

DATES OF TREATMENT: (date) ________________ **-- (date)** ________________

Records are being requested for the following purpose(s): ______________________________

Sensitive Information: I understand my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and /or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

Expiration: I understand this authorization will expire 12 months after signed unless an earlier date is specified here: ________________

Fees: I understand there may be fees I must pay to South Carolina Internal Medicine Associates and Rehabilitation, LLC before releasing any of the requested information. If records are printed, the Medical Records Research Fee is $15.00, plus $0.65 for the first 30 pages, and $0.50 for each additional page. If records are mailed, standard postage rates will apply. If records are saved on a USB, the fee is $12.50 per USB. Payment of fees can be made by cash, check, or credit card and can be mailed, phoned in to 803-749-1111, or made in person. I also understand South Carolina Internal Medicine Associates has the right to update this policy due to any future changes in the costs or regulations of healthcare.

Services: I understand refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

I hereby authorize *South Carolina Internal Medicine Associates and Rehabilitation, LLC* to use or disclose the health information as described above. I understand the information that I authorize the above mentioned person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

______________________________ ________________

Signature of Patient or Legal Representative **Date**

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Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)