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| **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: |  | This information should be released to: |  |
|  |  |  |  |
| [ ]  Clinical Assessment |  | Name: |       |
| [ ]  Clinical Service Notes / Progress Notes |  |  |  |
| [ ]  Admission and Discharge Dates, Diagnosis (Face Sheet) |  | Address: |       |
| [ ]  Treatment Plan (Plan of Care) |  |  |       |
| [ ]  Discharge Summary (Summary of Treatment) |  |  |       |
| [ ]  Medication / Physician’s Medication Orders |  |  |  |
| [ ]  History and Physical |  | Telephone No.: |       |
| [ ]  Psychiatric Evaluation (PMA) |  |  |  |
| [ ]  Billing and Payment Information |  | Fax Number: |       |
| [ ]  Alcohol and Drug Information |  |  |  |
| [ ]  Written Summary (copy attached) |  | Relationship: |       |
| [ ]  Progress Summaries |  |  |       |
| [ ]  HIV Information |  |  |       |
| [ ]  Continuity of Care Clinical Data  |  |  |       |
| [ ]  Other (specify): |       |
|  |  |
| 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** |
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| 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 |

**SCDMH FORM**

**DEC. 1999 (REV. JUL. 2022) M-450D**