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| **SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Authorization to Disclose SCDMH Protected Health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I, |  | | | | | | | | | | | , at |  | | | | | | | | | | | | | | | |
|  | Name of Patient | | | | | | | | | | |  | Address (Street, City, State, Zip) | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  |  | | | | | | | | | | | | | | | |
| Date of Birth: | |  | | | |  | | | | | | SSN: | |  | | | | | | | | | |  | | | | |
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| Authorize the release of my SCDMH health information, as specified below, for the following purpose: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
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| I authorize the release of the following information for the time period from: | | | | | | | | | | | | | | | |  | | | | | | | to | |  | | | |
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| Information from (name of specific Mental Health Center(s), SCDMH Hospital(s), SCDMH Nursing Facility(ies) or SCDMH Program(s)): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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): | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature of Patient / Personal Representative | | | | | | | | |  | Printed Name | | | | | | | | | | | | | | | |  | Date | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Authority if signed by Personal Representative: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **“I do hereby request that this authorization to disclose health information be Rescinded”** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Effective Date | | | |  | Signature | | | | | | | |  | | Printed Name | | | | | | | | | | |  | Date | |
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| Witness Signature | | | | | | | | |  | | Printed Name | | | | | | | | | | | | | | |  | Date | |

**SCDMH FORM**

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