AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, _____ (Name of requestor), at _____ Address (Street, City, State, Zip)

DOB _____, SS# _____, Medical Record # _____ authorize the release of my SCDMH health information, as specified below, for the following purpose: Placement Determination .

I authorize the release of the following information for the time period from: _____ to _____ .

☒ Information from **all** SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information from (name of specific hospital): _____

AND	**The information authorized to be released includes**:	**This information should be released to**:
☒	All information from above	Name: Tamassee DAR School
☐	Diagnoses	
☐	Clinical History & Evaluation	Address: PO Box 8
☐	Admission and Discharge Dates	
☐	Individualized Treatment Plan Progress Summaries	Tamassee, SC 29686
☐	Discharge Summary (Summary of Treatment)	
☐	Physician's Medication Orders	Telephone No.: (864) 944-3022
☐	History and Physical	
☐	Psychiatric History and Mental Status Examination	Relationship: Placement
☐	Consultant Notes	
☐	Billing and Payment Information	
☐	Written Summary (copy attached)	
☐	Other: _____	

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 named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. 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. I have been given a copy of this Authorization.

Signature of Individual/Personal Representative _____ Printed Name _____ Date _____

Authority if signed by Personal Representative _____

Signature of DMH Staff releasing information _____ Printed Name _____ Method of Release _____ Date Released _____

Patient Identification