# South Carolina Psychiatric Group – Release of Information Authorization

**68 Parkway Commons Way, Greer, SC 29650 - Phone: 864-877-5688 - Fax: 864-877-5684**

Patient Full Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

**NOTE: All items must be completed, along with signature and date**

| | |
|---|---|
| ☐ I hereby give my provider(s): Name: _____<br>South Carolina Psychiatric Group<br>68 Parkway Commons Way<br>Greer, SC 29650<br>Phone (864) 877-5688 Fax (864) 877-5684<br>**Permission to release information to the following:**<br>Name: _____<br>Address: _____<br>_____<br>Phone:_____ Fax:_____ | ☐ I hereby give:<br>Name: _____<br>Address: _____<br>_____<br>Phone:_____ Fax:_____<br>Permission to release information to my provider(s):<br>Name: _____<br>South Carolina Psychiatric Group<br>68 Parkway Commons Way<br>Greer, SC 29650<br>Phone (864) 877-5688 Fax (864) 877-5684 |

**Purpose of Release:** (Why is it needed?): ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ Continuing Care
☐ Disability ☐ School ☐ Other _____
(I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law)

**Treatment Date(s):** (When were you seen?): ☐ All Treatment Dates **OR** ☐ Treatment dates from _____ to _____
(please be specific)

**Information to be Released:** (What do you want sent or released? Check the appropriate box):
☐ ENTIRE RECORD (All Mental Health Notes/Information) ☐ Medication List ☐ Physician Progress/Visit Notes
☐ Demographics □ Other: _____

**Please initial:** _____ I acknowledge, and hereby consent to such, that the protected health information (PHI) released may contain information pertaining to psychiatric/psychological treatment, alcohol abuse, drug abuse, sexual assault, confidential information about communicable diseases including HIV (AIDS) or related illness. I acknowledge that I have read the above and authorize the disclosure of the protected health information (PHI) as stated.

I understand that: I may refuse to sign this authorization and that is it strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving this revocation. If the requester or receiver is not health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy of this information described on this form, for a reasonable copy fee, if I ask for it. However, we may refuse to provide you access to certain notes, reports, or information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative legal/forensic proceedings or for other reasons in accordance with state, federal, workers compensation and/or HIPAA law. I may receive a copy of this form after I sign it.

_____ _____
Printed Name of Patient or Legal Guardian / Representative Date
×_____ _____
Signature of Patient or Legal Guardian Representative Relationship to Patient, if Signed by Legal Guardian