



Release of Information Authorization

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last 4 Digits of SSN: \_\_\_\_\_ Phone #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

NOTE: All items, 1 through 6 must be completed, along with signature and date

Form with 6 sections: 1.) Release Records To, 2.) Obtain Records From, 3.) Release Instructions, 4.) Purpose of Release, 5.) Treatment Date(s), 6.) Information to be Released.

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records).

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment.

Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)

Printed Name of Patient or Legal Guardian / Representative

Date

Signature of Patient or Legal Guardian Representative

Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting GHS to send records, return this form to: 255 Enterprise Blvd., Suite 120, Greenville, S.C. 29615; Phone (864) 454-4600 Fax (864) 454-4654