GREENVILLE HEALTH SYSTEM

Authorization to Disclose Protected Health Information

Patient Name: ____ Date of Birth: ________________________

Last 4 Digits of SSN: _________________ Phone #: ____

This form must be completed in its entirety in order to be considered valid.

Release Records To: (**Where** do you want the information sent? **Who** may have the information?)	Name of Organization/Hospital or Medical Practice: ________________________ Address: ________________________ City: ________________ State: ____________ Zip Code: ________________ Day Phone Number: ________________ Fax Number: ________________
Obtain Records From: (**Who** has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: ________________________ Address: ________________________ City: ________________ State: ____________ Zip Code: ________________ Day Phone Number: ________________ Fax Number: ________________
Release Instructions: (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Mail ☐ My Chart / Epic ☐ Fax (To healthcare provider ONLY) ☐ Electronic ☐ Other ____________
Purpose of Release: (**Why** is it needed?)	☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ 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?)	☐ Treatment dates from ______ to _____ (please be specific) **OR** ☐ All Treatment Dates
Information to be Released: (**What** do you want sent or released? Check the appropriate box.)	☐ ENTIRE RECORD ☐ Immunization Records ☐ Medication List ☐ Physician Progress / Visit Notes ☐ Abstract Information History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports,. Emergency Department Reports, and Occupational / Physical Therapy Reports. ☐ Psychotherapy ☐ Test Results ☐ Demographics ☐ Other: _______

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 the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from this date or ______________.

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. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclose of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization. (NOTE: state law allows 45 days for Processing.)

____ ______________________________________

Printed Name of Patient or Legal Guardian / Representative — Date / Time

x____ ______________________________________

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