HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-386-3573 Fax: 877-322-0181

1608 N. Main St.
Conway, SC 29526
843-488-6030 Fax: 877-322-0181

243 Singleton Ridge Rd.
Conway, SC 29526
843-488-6030 Fax: 877-322-0181

145 Palmetto Pointe Dr.
Marion, SC 29571
843-423-2400 Fax: 877-322-0181

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ _____
LAST FIRST MI MAIDEN OR OTHER NAME

Date of Birth:____/____/____ ____-____-____ Medical Record #:_____
Mo/Day/Yr. SSN

Mailing Address:_____
Street/POB City St. Zip

Day Time Phone:_____ Evening Phone:_____ Email:_____

I hereby authorize Health Care Partners of SC, Inc. to (Please check):

- □ Obtain my medical records from the medical provider listed below
- □ Transfer my medical records to the medical provider listed below
- □ Release my medical records to the authorized person listed below

For questions or more information contact the patient's HCP Provider _____

Name:_____

Mailing Address:_____
Street/POB City St. Zip

Day Time Phone:_____ Fax:_____

Information to be released: **DATES**

- □ History & physical exam _____
- □ Progress notes _____
- □ Lab reports _____
- □ X-rays _____
- □ Others_____ _____
- □ Others_____ _____

I specifically authorize the release of information to:

- ☐ Substance abuse (including drugs & alcohol)
- ☐ Mental health (including psychotherapy notes)
- ☐ HIV related information (AIDS related testing)

_____
Signature of Patient or legal Guardian Date

PURPOSE OF DISCLOURE:

- □ Changing physicians □ Consultation/second opinion □ Continuing Care □ Legal
- □ School □ Insurance □ Worker's Comp
- □ Other_____

1. I understand that this authorization will expire on _____ (expires in 90 days from date of signing) or event for which this form is signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and shall be effective on the date notified, except to the extent action has already been taken.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by Health Care Partners of SC, Inc. for the purpose of

   _____ that
   a. By authorizing this release of information my health care and payment for my health care will not be affected if I do not sign this form
   b. I understand I may see and copy the information described on this form if I ask for it and that I may be provided a copy of this form after I sign it.
   c. I have been informed that Health Care Partners of SC, Inc. □**will** □**will not** receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with South Carolina stature I will pay a fee of $_____ (there is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment).

_____ _____ or _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____ _____ _____
RECORDS RECIVED BY DATE RELATIONSHIP TO PATIENT WITNESS DATE

FOR OFFICE USE ONLY
DATE REQUEST FILLED_____ FILLED BY_____

INDENTIFICATION PRESENTED:_____ FEE COLLECTED $_____