HEALTH CARE PARTNERS OF SC, INC.

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

243 Singleton Ridge Rd.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

1608 N. Main St.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

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

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL MAIDEN OR OTHER NAME

Date of Birth: ____/____/____ SSN#: _____ Medical Record #: _____
MONTH / DAY / YEAR

Mailing Address: _____ City: _____ State: _____ Zip: _____

Daytime 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

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

Name of Medical Provider: _____ Email: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Fax: _____

Information to be released:	*DATES*
❑ History & physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-rays	_____
❑ Sliding fee/Financial documentation	_____
❑ Other: _____	_____

I specifically authorize the release of information to:
❑ Substance abuse (including drugs & alcohol)
❑ Mental health (including psychotherapy notes)
❑ HIV related information (related to testing)

_____
Signature of parent or legal guardian

_____
Date

PURPOSE OF DISCLOSURE: ❑ Changing Physicians ❑ Consultation/Second Opinion ❑ Continuing Care ❑ Insurance
❑ Worker's Comp ❑ Sliding Fee Applications ❑ School ❑ Legal

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 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 SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____ _____ _____ _____
RECOVERED BY DATE RELATIONSHIP TO PATIENT WITNESS DATE

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ FILLED BY: _____
IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $ _____

revised 6.6.22