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	6874 Hwy 908 Gresham, SC 29546 843-352-8772 Fax: 877-322-0181	1606 B Main St. Conway, SC 29526 843-488-6350 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/ Genetic testing 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: $ ______________________