



ONE WELLNESS BOULEVARD, # 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111
FAX: (803) 749-0050

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize South Carolina Internal Medicine Associates and Rehabilitation, LLC to Use or Disclose Health Information as Described Below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

South Carolina Internal Medicine Associates and Rehabilitation, LLC shall, as promptly as required under the circumstances, respond to the request of medical records not later than 30 days from the receipt of the request or if the medical record is not maintained or accessible on-site, not later than 60 days after receipt of the request.

Patient Name at time of treatment: _____ Date of Birth: _____

Street Address: _____ Social Security #: _____

City/State/Zip: _____ Telephone #: _____

SCIM Physician Name: _____

Name of Person/Facility Authorized to RECEIVE the information _____

Address: _____ Telephone #: _____ Fax #: _____

- Mail Records Pick-up records Fax records to #: _____

Name of Person/Facility Authorized to RELEASE the information _____

Address: _____ Telephone #: _____ Fax #: _____

Information to be USED/RELEASED: (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Patient Identification/Diagnoses list | <input type="checkbox"/> Physical Therapy Reports |
| <input type="checkbox"/> Office notes/physician dictation | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Laboratory tests | <input type="checkbox"/> Pulmonary Function Tests |
| <input type="checkbox"/> EKG/Cardiovascular | <input type="checkbox"/> Bill |
| <input type="checkbox"/> Radiology Films- Type _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radiology reports | |

*Information for treatment period: FROM: (date) _____ TO: (date) _____ (All Dates of Treatment)

*Records are being requested for the following purpose(s): _____

Sensitive Information: I understand my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and /or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

Expiration: I understand this authorization will expire 12 months after signed unless an earlier date is specified here: _____

Fees: I understand there may be fees that I must pay to South Carolina Internal Medicine Associates and Rehabilitation, LLC before releasing any of the requested information. Fee calculation: \$15.00 – Medical Records Research Fee plus \$0.65 for the first 30 pages, each additional page will be \$0.50 per page. If records are requested to be mailed, standard postage rates will also be applied to the Medical Records Fees. Payment of fees can be made by cash, check, or credit card and can be mailed, phoned in to 803-749-1111 ext. 153, or made in person.

Services: I understand refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

Signature of Patient or Legal Representative

Date

Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)