



1 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

**** TO ENSURE RECORDS ARE RELEASED IN A TIMELY MANNER, THE FOLLOWING MUST BE COMPLETED ENTIRELY.****

Patient Name (at time of treatment): _____

Date of Birth: _____ Telephone #: _____ SCIM Provider Name: _____

Requesting information FROM: _____

Address: _____ Telephone #: _____

SEND information TO: _____

Address: _____ Telephone #: _____

Mail Pick-up Fax (#: _____) Electronic *ONLY includes: Recent Lab Results, Problem List, Medication List and Allergy List

E-mail (not password protected): _____

USB (Additional costs will apply)

Information REQUESTED: (Check all that apply)

<input type="checkbox"/> Patient Identification/Diagnoses list	<input type="checkbox"/> Radiology reports
<input type="checkbox"/> Health Summary	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Office notes/physician dictation	<input type="checkbox"/> All of the above
<input type="checkbox"/> Labs/Pathology	<input type="checkbox"/> Other: _____
<input type="checkbox"/> EKG/Cardiovascular	

DATES OF TREATMENT: (date) _____ **-- (date)** _____

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 I must pay to South Carolina Internal Medicine Associates and Rehabilitation, LLC before releasing any of the requested information. If records are printed, the Medical Records Research Fee is \$15.00, plus \$0.65 for the first 30 pages, and \$0.50 for each additional page. If records are mailed, standard postage rates will apply. If records are saved on a USB, the fee is \$12.50 per USB. Payment of fees can be made by cash, check, or credit card and can be mailed, phoned in to 803-749-1111, or made in person. I also understand South Carolina Internal Medicine Associates has the right to update this policy due to any future changes in the costs or regulations of healthcare.

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

I hereby authorize South Carolina Internal Medicine Associates and Rehabilitation, LLC to use or disclose the health information as described above. I understand the information that I authorize the above mentioned person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Signature of Patient or Legal Representative

Date

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