PRISMA HEALTH

Release of Information Authorization

Patient Name:_____Date of Birth:_____

Last 4 Digits of SSN: _____Phone #:_____E-mail address_____

NOTE: All items, 1 through 6 must be completed, along with signature and date

1.) Release Records To: (**Where** do you want the information sent? **Who** may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address:_____ City:_____State:_____Zip Code: _____ Day Phone Number:_____Fax Number: _____		
2.) Obtain Records From: (**Who** has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: _____ Address:_____ City:_____State:_____Zip Code: _____ Day Phone Number:_____Fax Number: _____		
3.) Release Instructions: (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Mail ☐ My Chart / Epic ☐ Fax (To healthcare provider ONLY) ☐ Electronic ☐ Other _____		
4.) Purpose of Release: (**Why** is it needed?)	☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ Disability ☐ School ☐ Other _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by SC Law.		
5.) Treatment Date(s): (**When** were you seen?)	☐ Treatment dates from_____to_____(please be specific) **OR** ☐ All Treatment Dates		
6.) Information to be Released: (**What** do you want sent or released? Check the appropriate box)	☐ Abstract Information: History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports, Emergency Department Reports	☐ Immunization Records ☐ Medication List ☐ Physician Progress / Visit Notes ☐ Other: _____	☐ Psychotherapy ☐ Test Results ☐ Demographics

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS. This information may have been disclosed to you from records protected by federal confidentiality rules/HIPAA Privacy Regulations. This prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted in written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 160 & 164. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from the date of signature unless otherwise specified.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.

Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)

Be aware the processing of this document will release the entire medical record requested which may include information from other providers.

_____ _____

Printed Name of Patient or Legal Guardian / Representative — Date

_____ _____

Signature of Patient or Legal Guardian Representative — Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting Prisma Health to send records, return this form to:
Greenville Market – 255 Enterprise Blvd., Suite 120, Greenville, SC 29615; Phone (864) 454-4600 Fax (864) 454-4654, ROI@prismahealth.org
Columbia Market – HIM Dept, Taylor at Marion Street, Columbia, SC 29220; Phone (803) 296-5865 Fax (803) 296-5869,HIMROI@prismahealth.org