Authorization for Release of Information

PATIENT NAME (Last, First MI): _____ DOB: (MMDDYY) _____

SSN#: _____ GCDC Internal ID # (OFFICE USE ONLY)_____

ADDRESS: _____

I hereby authorize the **Greenville County Detention Center – Medical Dept.** to release information from my medical record as indicated below to:

NAME (Last, First MI):_____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

DAY PHONE: _____ FAX: _____RELATIONSHIP TO PATIENT: _____

INFORMATION TO BE RELEASED:
DATES: _____

__ History and physical exam ____
__ Progress notes ____
__ Lab reports ____
__ X-ray reports ____
__Medication ____
__ Other: ____

I specifically authorize the release of information relating to:

___ Substance abuse (including alcohol/drug abuse)
___ Mental health (including psychotherapy notes)
___ HIV related information (AIDS related testing)

_____
Patient Signature required Date

PURPOSE OF DISCLOSURE: ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): _____

1. I understand that this authorization will expire on (date) _____.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____