AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Form Origination Date: 1/2000

Version: 9   Version Date: 5/19

Patient Name: ______________________

Date of Birth: ______________________

Email Address: ______________________

Phone #: ______________________

Health Record #: ______________________

This form must be ***COMPLETED*** in its entirety in order to be considered valid.

MUSC Release Records To / Obtain From: (***Where*** do you want the information sent? **OR** ***Who*** may receive the information?)	Individual **OR** Organization: ______________ Email Address: ____________ Address: ______________________ City: ____________ State: ______ Zip Code: ________ Day Phone Number: ____________ Fax Number: ____________
Release Instructions: (***How*** do you want the information?)	**Release Method / Format requested: (Check ONE)** ☐ Mail ☐ DVD/CD ☐ Email ☐ *Fax* (For healthcare providers / organizations as permitted) ☐ Other ________
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 S.C. Law.**
Treatment Date(s): (***When*** were you seen?)	☐ Treatment dates from ________ to ________ (Please be specific) **OR** ☐ **ALL** Treatment Dates
Information to be Released: (***What*** do you want sent or released? Check the appropriate box.)	☐ **Entire** Medical Record **OR** ☐ Orthodontic treatment notes (Including orthodontic-related photos and x-rays) ☐ Radiology Images / DVD (**NOT** Included in Entire Record) ☐ Periodontic Charting ☐ Billing/Financial Statements ☐ Treatment Progress / Visit Notes ☐ Other: ____________

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

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 Dental Health Information Services Department (Dental 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 below. I understand that only records available as of this date will be provided in response to this request. Should I need additional records in the future; a new request will be required.

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 the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization. (NOTE: HIPAA LAW ALLOWS 30 DAYS from receipt for processing.)

____
Printed Name of Patient or Legal Guardian / Representative

____
Date

____
Signature of Patient or Legal Guardian/Representative

____
Relationship to Patient, if signed by Legal Guardian

____
Witness Signature

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

To contact Dental Health Information Services (Dental Records) in writing, the address is: 29 Bee St. / DC 606/MSC 507 Charleston, South Carolina 29425-3490. The phone number is: (843) 792-2101 Option 7. Fax number is: (843) 792-7009. Email address is: cdmimages@musc.edu.