MUSC
Medical University of South Carolina

Fax completed form to:
843-792-7009
Email completed form to:
cdmimages@musc.edu

**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:**<br>(***Where*** do you want the information sent?<br>**OR**<br>***Who*** may receive the information?) | Individual **OR** Organization: _____ Email Address: _____<br>Address: _____<br>City: _____ State: _____ Zip Code: _____<br>Day Phone Number: _____ Fax Number: _____ |
| **Release Instructions:**<br>(***How*** do you want the information?) | **Release Method / Format requested: (Check ONE)**<br>☐ Mail ☐ DVD/CD ☐ Email ☐ *Fax* (For healthcare providers / organizations as permitted) ☐ Other _____ |
| **Purpose of Release:**<br>(***Why*** is it needed?) | ☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance<br>☐ Disability ☐ School ☐ Other _____<br>**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):**<br>(***When*** were you seen?) | ☐ Treatment dates from _____ to _____ (Please be specific) **OR** ☐ **ALL** Treatment Dates |
| **Information to be Released:**<br>(***What*** do you want sent or released? Check the appropriate box.) | ☐ **Entire** Medical Record **OR**<br>☐ Orthodontic treatment notes (Including orthodontic-related photos and x-rays)<br>☐ Radiology Images / DVD (**NOT** Included in Entire Record)<br>☐ Periodontic Charting<br>☐ Billing/Financial Statements<br>☐ Treatment Progress / Visit Notes<br>☐ 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:** College of Dental Medicine / Attention Records / MSC 507/ Charleston, South Carolina 29425-3490. The phone number is: (843) 876-7645 option 4. Fax completed form to: (843) 792-7009. Email completed form to: cdmimages@musc.edu.