



Requesting records from:

- MUSC Health Charleston MUSC Health Chester MUSC Health Columbia
- MUSC Health Columbia Northeast/Clinics MUSC Health Florence
- MUSC Health Kershaw MUSC Health Lancaster
- MUSC Health Marion MUSC Health Ambulatory Clinics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION



AUTHRELS

IMPORTANT: FAILURE TO FULLY COMPLETE MAY INVALIDATE THIS AUTHORIZATION.

Patient Name: _____ Patient Date of Birth: _____ Last 4 digits of SSN: _____ MRN: _____
(Internal Only)
 Patient Phone: _____
 Patient's Address: _____

<p>Send Record To: (Identified Person or Company or Facility)</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: _____</p> <p>Fax Number: _____</p> <p>Email Address: _____</p> <p><small>Encrypted email (Important: I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by other; in addition I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive My Health Information on an unencrypted e-mail, I am acknowledging and accepting these risks. I understand there may be a fee for a copy of My Health Information.</small></p>	<p>Types of Medical Records to be released (check all that apply)</p> <p><input type="checkbox"/> Entire Record (Radiology Images are NOT included)</p> <p><input type="checkbox"/> Abstract (Contains: History & Physical, consults, lab & radiology reports, discharge summary, operative/procedure reports, Emergency Department reports and Occupational/Physical Therapy reports)</p> <p><input type="checkbox"/> Radiology Images/DVD <input type="checkbox"/> Immunization Records</p> <p><input type="checkbox"/> Medication List <input type="checkbox"/> Physician progress notes/visit notes</p> <p><input type="checkbox"/> Final Bill <input type="checkbox"/> Other: _____</p> <p>FOR MUSC Dental RECORDS ONLY:</p> <p><input type="checkbox"/> Entire Dental Record <input type="checkbox"/> Orthodontic Treatment Notes/photos/x-rays</p> <p><input type="checkbox"/> Periodontic charting <input type="checkbox"/> Treatment Progress/Visit Notes</p> <p><input type="checkbox"/> Billing/Financial Statements <input type="checkbox"/> Radiology Images</p> <p>Substance Use Disorder (SUD) records protected under 42 C.F.R. Part 2 and 45 C.F.R. pts 160 & 164:</p> <p><input type="checkbox"/> All of my SUD records</p> <p><input type="checkbox"/> Only the following SUD records (be as specific as possible. i.e. discharge summary only, labs only, etc.: _____)</p>
<p>Purpose of the Release:</p> <p><input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Patient/Guardian/Legal Rep</p> <p><input type="checkbox"/> Military <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> School</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Information that can be released:</p> <p>Treatment dates from _____ to _____</p> <p>(Please be specific) OR <input type="checkbox"/> All Treatment Dates</p>	<p>Release Method: (Check One)</p> <p><input type="checkbox"/> Mail <input type="checkbox"/> Mychart (Rad Images & Dental excluded) <input type="checkbox"/> Fax</p> <p><input type="checkbox"/> Encrypted E-mail <input type="checkbox"/> Other: _____</p> <p>I understand that all fees will be in compliance with applicable laws. I agree to pay this fee. (If a method is not selected, the information will be mailed.)</p>
<p>I authorize the release of the records as indicated above and understand that the release may include sensitive information (mental and behavioral health, genetic testing, HIV/AIDS, communicable/infectious diseases, substance use disorder(s), and sexual assault)</p> <p><small>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) or Dental Health Information Services (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.</small></p> <p><small>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.</small></p> <p><small>I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524.</small></p> <p><small>I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information.</small></p> <p><small>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</small></p> <p><small>I understand I will be given a copy of this authorization.</small></p> <p><small>I understand there may be fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.</small></p> <p style="text-align: center;">Attach a copy of the patient/legal guardian/representative identification to this authorization. (NOTE: HIPAA LAW ALLOWS 30 DAYS from receipt for processing.)</p>	

 Printed Name of Patient or Legal Guardian / Representative

 Signature of Patient or Legal Guardian/Representative

 Relationship to Patient, if signed by Legal Guardian

 Date

 Witness Signature

Document(s) (Court Orders, Certificate of Appointments, Power of Attorneys) of patient representative's authority must be attached if patient is not signing.

Facility Location Information:

To contact **MUSC Health Charleston** - Health Information Services (Medical Records) in writing, the address is: 3 South Park Circle / Bldg. 3 / Suite 103 / Attn: Release of Information / Charleston, SC 29407. The phone number is (843) 792-3881; Fax number is (843) 792-5460 or (843) 876-8055. Email: ROIAuthrequest@MUSC.edu

To contact **MUSC College of Dental Medicine** - Health Information Services (Dental Records) in writing, the address is: 29 Bee St./DC606/MSC507 / Charleston SC 29425. The phone number is (843) 792-2101, Option 7, Fax number is (843) 792-7009. Email: cdmimages@musc.edu.

To contact **MUSC Health Columbia Downtown/Northeast/Clinics** -- Health Information Services (Medical Records) in writing, the address is 2435 Forest Drive, Columbia, SC 29204. The phone number is (803) 256-5722, Fax number is (803) 400-5065. Email: COLROI-authrequest@musc.edu

To contact **MUSC Health Chester** -- Health Information Services (Medical Records) in writing, the address is 1 Medical Park Drive Chester, SC 29706. The phone number is (803) 581-3151, Ext. 5214; Fax number is (843) 985-9624. Email: ches-roiauthrequest@musc.edu

To contact **MUSC Health Florence** - Health Information Services (Medical Records) in writing, the address is 805 Pamplico Hwy. / Florence, SC 29505. The phone number is (843) 674-2160; Fax number is (843) 674-2198. Email: flor-roi-request@musc.edu

To contact **MUSC Health Kershaw** -- Health Information Services (Medical Records) in writing, the address is 1315 Roberts Street, Camden SC 29020. The phone number is (803) 713-6232; Fax number is (803) 713-6600 or (803) 713-6327. Email: KMCROI-authrequest@musc.edu

To contact **MUSC Health Lancaster** - Health Information Services (Medical Records) in writing, the address is 800 West Meeting Street / Lancaster, SC 29720. The phone number is (803) 313-3146 or (803) 313-3147, Fax number is (803) 286-1871. Email: lanc-roi-requests@musc.edu

To contact **MUSC Health Marion** - Health Information Services (Medical Records) in writing, the address is 2829 East Highway 76 / Mullins, SC 29574. The phone number is (843) 431-2428, Fax number is (843) 431-2432. Email: mari-roi-auth@musc.edu