

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

IMPORTANT: FAILURE TO FULLY COMPLETE MAY INVALIDATE THIS AUTHORIZATION.

Patient Information: I give permission to release the health information of:

Patient Name: _____ Patient Date of Birth: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Last 4 digits of Social Security #: _____ Telephone #: _____

(Although MUSC will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.)

Release Records From:	Release Records To: (Identified Person or Company or Facility)
Name of Facility/Location of Office: _____ Name of Provider: _____ Address: _____ _____	Name: _____ Address: _____ _____ Phone Number: _____ Fax Number: _____ Email Address: _____

Types of Medical Records to be released (check all that apply)

☐ Entire Record (Radiology Images are NOT included)

☐ Abstract (Contains: History & Physical, consults, lab & radiology reports, discharge summary, operative/procedure reports, Emergency Department reports and Occupational/Physical Therapy reports)

☐ Radiology Images/DVD ☐ Immunization Records ☐ Medication List ☐ Physician progress notes/visit notes

☐ Final Bill ☐ Other: _____

For MUSC Dental Records Only:

☐ Entire Record ☐ Treatment Progress/Visit Note ☐ Radiology Images

Substance Use Disorder (SUD) records protected under 42 C.F.R. Part 2 and 45 C.F.R. pts 160 & 164:

☐ All of my SUD records ☐ Only the following SUD records (be as specific as possible, i.e., discharge summary only, labs only, etc.): _____

Purpose of the Release:

☐ Continuing Care ☐ Legal ☐ Patient/Guardian/Legal Rep

☐ Military ☐ Insurance ☐ Disability ☐ School

☐ Other (specify): _____

Information that can be released:

Treatment dates from _____ to _____ (Please be specific) **OR** ☐ All Treatment Dates

Release Method: (Check One)

☐ Mail ☐ Mychart (Rad Images & Dental excluded) ☐ Fax

☐ Encrypted E-mail ☐ Other: _____

Encrypted email (Important: I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others. By choosing to receive My Health Information on an unencrypted e-mail, I am acknowledging and accepting these risks.

If a method is not selected, the information will be mailed.

Authorization Statement: I authorize the release of the records as indicated above and understand that the release may include sensitive information, including mental and behavioral health, genetic testing, HIV/AIDS, communicable/infectious diseases, substance use disorder(s), and sexual assault.

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 Management Department (Medical Records) or Dental Health Information Management (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 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 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 I will be given a copy of this authorization.

I understand there may be fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.

Attach a copy of the patient/legal guardian/representative identification 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

Documentation (Court Orders, Certificates of Appointment, Powers of Attorney) establishing the patient representative's authority must be attached if patient is not signing.



Authorization to Release Protected Health Information

Facility Location Information:

MUSC Health Charleston - Health Information Management (Medical Records): Parkshore Centre / 1 Poston Road / Suite 135 / Charleston, SC 29407

Phone: (843) 792-3881 Fax: (843) 792-5460

Email: roiauthrequest@MUSC.edu

MUSC College of Dental Medicine - Health Information Management (Dental Records): Parkshore Centre / 1 Poston Road / Suite 135 / Charleston, SC 29407

Phone: (843) 792-3881 Fax: (843) 792-5460

Dental Billing: (843) 792-7680

Email: cdm-roi-auth@musc.edu

MUSC Health Columbia Downtown/Northeast - Health Information Management (Medical Records): 2435 Forest Drive, Columbia, SC 29204

Phone: (803) 256-5722 Fax: (803) 400-5065

Email: colroi-authrequest@musc.edu

MUSC Health Chester - Health Information Management (Medical Records): 1 Medical Park Drive, Chester, SC 29706

Phone: (803) 581-3151, Ext. 5214. Fax: (843) 985-9624

Email: ches-roiauthrequest@musc.edu

MUSC Health Florence/Black River/Leatherman - Health Information Management (Medical Records): 200 Dozier Blvd, Florence, SC 29501

Phone: (843) 674-2160 Fax: (843) 674-2197

Email: flor-roi-request@musc.edu

MUSC Health Kershaw - Health Information Management (Medical Records): 1315 Roberts Street, Camden, SC 29020

Phone: (803) 713-6232 Fax: (803) 713-6600 or (803) 713-6327

Email: kmcroi-authrequest@musc.edu

MUSC Health Lancaster - Health Information Management (Medical Records): 800 West Meeting Street, Lancaster, SC 29720

Phone: (803) 313-3146 or (803) 313-3147 Fax: (803) 286-1871

Email: lanc-roi-requests@musc.edu

MUSC Health Marion - Health Information Management (Medical Records): 2829 East Highway 76, Mullins, SC 29574

Phone: (843) 431-2428 Fax: (843) 431-2432

Email: mari-roi-auth@musc.edu

MUSC Health Orangeburg - Health Information Management (Medical Records): 3000 St. Matthews Road, Orangeburg, SC 29118

Phone: (803) 395-2272 Fax: (803) 395-4011

Email: obg-roi-auth@musc.edu