ROPER ST. FRANCIS PHYSICIAN PARTNERS

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____ Date of Birth: _____

Street Address: _____ Social Security # (Last 4 Digits): XXX – XX – _____

City, State, Zip: _____ Best Contact #: (_____)_____

Email Address: _____ May we leave a message at this number: ☐Yes ☐ No

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
_____ Name of Physician Practice	_____ Name of Facility, Person or Company
_____ City, State, Zip	_____ City, State, Zip
_____ Phone Number Fax Number	_____ Phone Number Fax Number

PURPOSE OF RELEASE (check reason): ☐ Request of Individual/Personal Use ☐ Continued Patient Care ☐ Insurance

☐ Legal Purpose (including discussions & proceedings) ☐Other_____

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____**To** _____

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED (check all that apply):

☐ Office/Clinic Summary (may include most recent office visits, physical exam, consults, and diagnostic test results)
☐ Progress Notes
☐ Laboratory Reports
☐ Radiology Reports
☐ Other: _____
☐ Entire Record (not including psychotherapy notes)

Fees May Apply. Requests for more than ten pages will be processed by our copy service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

FORMAT (check one)	**DELIVERY METHOD (check one)**
☐ Paper copy	☐ Reg.US Mail
☐ Email Address noted above, where permitted	☐ Pick-up
☐ Jump Drive (where available)	☐ Fax, where permitted
☐ CD (where available)	☐ Secure Email, where permitted
☐ Other: _____	☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- RSFH will not share or use my health information without my permission other than by ways listed in RSFH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.rsfh.com.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: _____**Patient Signature:** _____ **Date:**____/_____/____

NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit/ Next of Kin ☐ Other: _____

RETURN COMPLETED FORM IN PERSON TO YOUR PROVIDER OR RETURN BY MAIL, E-MAIL OR FAX WITH A COPY OF YOUR PHOTO I.D.

Roper St. Francis Physician Partners
Attention: Release of Information Department
8536 Palmetto Commerce Parkway
Ladson, SC 29456
Phone: (843) 402-5015 Fax: (770) 810-9127
Email: RSFPPROI@RSFH.COM

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