MUSC Health

MRN_____
(Internal Only)

AUTHRELSE

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 confidentially of all email communications.)

Release Records From:	**Release Records To: (Identified Person or Company or Facility)**
Name of Facility/Location of Office:_____	Name: _____
Name of Provider: _____	Address:_____
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 Dental Record □ Orthodontic Treatment Notes/photos/x-rays □ Periodontic charting □ Treatment Progress/Visit Notes

□ Billing/Financial Statements □ 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:	**Release Method: (Check One)**
□ 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	□ 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.**)

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)

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.

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

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 Management (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 Management (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 Management (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 Management (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 Management (Medical Records) in writing, the address is 805 Pamplico Hwy. / Florence, SC 29505. The phone number is (843) 674-2160; Fax number is (843) 674-2197. Email: flor-roi-request@musc.edu

To contact **MUSC Health Kershaw** - – Health Information Management (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 Management (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 Management (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

To contact **MUSC Health Orangeburg** – Health Information Management (Medical Records) in writing, the address is 3000 St. Matthews Road / Orangeburg, SC 29118. The phone number is (803) 395-2272, Fax number is (803) 395-4011.
Email: OBG-ROI-Auth@musc.edu