Authorization for Release of Protected Health Information

Patient's 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

REQUEST INFORMATION FROM: (select one)

☐ All Roper St. Francis Physicians Partners Providers

☐ Practice(s) Name ______________________________
____

☐ Provider(s) Name ______________________________

SEND INFORMATION TO:

____
Name of Person, Facility, or Company

____
City, State, Zip

____
Phone Number Fax Number

____
Email address

PURPOSE OF RELEASE (check one): ☐ Request of Individual Use ☐ Continued Patient Care ☐ Insurance ☐ Legal Purpose ☐ 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/ Visit Summary (may include most recent office visits, physical exam, consults, and diagnostic test results)

☐ Progress Notes ☐ Laboratory Reports ☐ Radiology Reports

☐ Entire Record (not including psychotherapy notes) ☐ Other: ______________________________

FEES MAY APPLY. Requests for medical records will be processed by our Release of Information Department who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

DELIVERY METHOD (check one): ☐ Mail ☐ Pick-up ☐ Fax to number above ☐ Secure Email/E-delivery ☐ 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: ______________________

To request copies of Roper St. Francis Physician Partners medical records, return this completed form in person to your provider or return by mail, email or fax with a copy of your photo I.D.

Please allow up to 30 days for your request to be processed. If an extension is needed, you will be notified.

Roper St. Francis Physician Partners
Attention: Release of Information Department
8536 Palmetto Commerce Parkway
Ladson, SC 29456

Phone: (843) 402-5017 Fax: (770) 810-9127 Email: RSFPPROI@RSFH.COM