

**Authorization to Release Protected Health Information**

Patient's Legal Name: _____	Date of Birth: _____
Street Address: _____	Social Security # (Last 4 Digits): _____
City, State, Zip: _____	Best Contact #: (_____) _____
Email Address: _____	May we leave a message at this number: <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>TREATMENT LOCATIONS:</b>  <input type="checkbox"/> Bon Secours St. Francis Hospital <input type="checkbox"/> Roper Hospital <input type="checkbox"/> Roper St. Francis Berkeley Hospital <input type="checkbox"/> Roper St. Francis Mount Pleasant Hospital <input type="checkbox"/> Roper St. Francis Physician Partners	<b>TREATMENT DATES:</b>  <b>FROM:</b> _____  <b>TO:</b> _____	<b>SEND INFORMATION TO:</b> (complete if different than the patient)  _____ Individual or Organization  _____ Street Address, City, State, Zip  _____ Phone Number (_____) _____  _____ Fax Number (_____) _____  _____ Email Address
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**PURPOSE OF RELEASE:** (select one)  Continued Patient Care  Individual Use  Insurance  Legal Purpose  Other \_\_\_\_\_

**INFORMATION TO BE RELEASED:** (select all that apply) (psychotherapy notes are NOT included)

<input type="checkbox"/> Progress Notes, Consult Notes, History & Physical Notes, ER Notes	<input type="checkbox"/> Office/Clinic Notes
<input type="checkbox"/> Operative/Procedure Notes	<input type="checkbox"/> ER Notes
<input type="checkbox"/> Pathology Notes	<input type="checkbox"/> Laboratory Notes
<input type="checkbox"/> Radiology Notes (does NOT include images/pictures)	<input type="checkbox"/> Other: _____

**DELIVERY METHOD:** (select one)  Email  Mail  Fax  CD  Pick-Up  
 Someone from the Medical Records Office will call you to pre-arrange a convenient time and location for pick-up.

**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](http://www.rsfh.com).
- I have a right to receive a copy of this form upon request.
- I understand that HIPAA allows 30 days from receipt for processing. If an extension is needed, I will be notified in writing.
- I understand that federal and state laws allow a fee to be charged for the copying of patient records and that you will be responsible for the payment of such fees. Fees for records delivered in electronic format via Email is a flat fee of \$6.50. Fees for records delivered in paper format are cost-based, per page, but will not exceed \$50.00.
- I understand that this permission expires one year after the date of my signature unless I elect an earlier date of: \_\_\_\_\_

**Signature of Patient/Patient's Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**If Legal Representative, Print Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**NOTE: If signature is not of the patient, supporting documentation of authority must be provided.**

Complete all above sections of this form and return it by mail, fax, or email with a copy of your photo I.D. to the attention of: **RSFH Release of Information.**  
**Mailing Address:** 316 Calhoun St. Charleston, SC 29401. **Fax Number:** (770) 810-9127. **Email Address:** [RSFHROI@rsfh.com](mailto:RSFHROI@rsfh.com).

Date ROI Received:	ID verified by:	Title:
ROI Prepared & Released By:	Title:	Date ROI Released: