ROPER ST. FRANCIS PHYSICIAN PARTNERS

Authorization for Release of Protected Health Information

Patient's 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 (RSFPP)

☐ Specific Practice(s) Name _____

_____

☐ Specific Provider(s) Name _____

_____

SEND INFORMATION TO (complete only if different than patient)**:**

_____
Name of Person, Facility, or Company

_____
Street Address, City, State, Zip

(_____)_____(_____)_____
Phone Number Fax Number

_____
Email address

PURPOSE OF RELEASE (check one)**:** ☐ 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 ☐ Billing Records

☐ 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 ☐ 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 Patient's Name: _____**Patient's 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 a copy of your medical record, complete form and return it with a copy of your valid photo I.D. to your provider or by mail, email or fax to:

Mailing Address Only (walk-ins not allowed)
RSFPP Release of Information Department
8536 Palmetto Commerce Parkway
Ladson, SC 29456

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

It may take up to 30 days for your request to be processed. If an extension is needed, you will be notified in writing.

If you need to send your records to your provider, then send them directly to the practice, not to this address.

This form should be used only to request a copy of your record.