BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:_____

CHART #:_____

DOB:_____

SSN:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:

_____
_____
_____
_____

Persons/organizations receiving the information:

_____
_____
_____
_____

Specific description of information (including date(s)):

_____
_____
_____

Section B: Must be completed only if BJHCHS, Inc. has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?_____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No____
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care treatment and the payments will not be affected if I do not sign this form. **Initials:**_____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

Section C: Must be completed for all authorizations

State and Federal laws (42 CFR Part 2) require special permission to release information related to diagnosis and/or treatment of the following conditions, please initial for consent to release records:

_____ Alcohol/Substance Abuse _____Behavioral/Mental Health _____ HIV (AIDS) _____ Genetics

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __ __/ __ __/ __ __ __ __ (DD/MM/YYYY). **Initials:**_____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **Initials:**_____

3. _____ **Signature of patient or patient's representative** (Form MUST be completed before signing)

_____ Date

Printed name of patient's representative:_____ **Relationship to the patient:**_____

I_____, hereby certify and attest that I am duly authorized to act as the personal representative and I have the lawful authority to sign this authorization.

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.