BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:_____

CHART #:_____

DOB:_____

SSN:_____

AUTHORIZATION FOR REQUEST 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:

BEAUFORT JASPER HAMPTON COMPREHENSIVE HEALTH SERVICES

P.O. BOX 357 RIDGELAND, SC 29936

MEDICAL RECORDS DEPARTMENT

PHONE # 1-843-987-7400 FAX # 1-843-987-7498

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

_____

Note: State law require that you give specific permission to release the information below even if you initialed a box below. Indicate your permission for the to release any of the following information.

Genetic Information _____ **HIV/AIDS** _____

Substance/Alcohol Abuse _____ **Mental Health/ Behavioral Health** _____

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

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:_____

_____ _____

Signature of patient or patient's representative Date
(Form MUST be completed before signing)

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.