ROPER ST. FRANCIS HEALTHCARE

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: ☐ Yes ☐ No

TREATMENT LOCATIONS:	**TREATMENT DATES:**	**SEND INFORMATION TO:** (complete if different than the patient)
☐ Bon Secours St. Francis Hospital ☐ Roper Hospital ☐ Roper St. Francis Berkeley Hospital ☐ Roper St. Francis Mount Pleasant Hospital ☐ Roper St. Francis Physician Partners	**FROM:** _____ **TO:** _____	_____ Individual or Organization _____ Street Address, City, State, Zip Phone Number (_____) _____ Fax Number (_____) _____ Email Address _____

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)

☐ Progress Notes, Consult Notes, History & Physical Notes, ER Notes
☐ Office/Clinic Notes
☐ Fetal Monitor Strips
☐ Operative/Procedure Notes
☐ ER Notes
☐ Pathology Notes
☐ Laboratory Notes
☐ Radiology Notes (does NOT include images/pictures)
☐ 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.
- 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.

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