CID#:

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Authorization to Disclose SCDMH Protected Health Information

l,	, at			
Name of Patient Address (Street, City, State, Zip)				
Date of Birth: SSN:				
Authorize the release of my SCDMH health information, as specified below, for the following purpose:				
I authorize the release of the following information for the time period from: to				
Information from (name of specific Mental Health Berkeley Community Mental Health Cent P.O. Box 1030	er Phone: 843			
Moncks Corner, SC 29461	1777. 010	, , 61 , 666		
And the information authorized to be released	includes:	This information should be released	<u>to</u> :	
☐ Clinical Assessment ☐ Clinical Service Notes / Progress Notes ☐ Admission and Discharge Dates, Diagnosis (Face) ☐ Treatment Plan (Plan of Care) ☐ Discharge Summary (Summary of Treatment) ☐ Medication / Physician's Medication Orders ☐ History and Physical ☐ Psychiatric Evaluation (PMA) ☐ Billing and Payment Information ☐ Alcohol and Drug Information ☐ Written Summary (copy attached) ☐ Progress Summaries ☐ HIV Information ☐ Continuity of Care Clinical Data ☐ Other (specify):	e Sheet)	Fax Number: Relationship:		
I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed: This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:				
I understand that information disclosed may be subject to re-disclosure by the entity name above. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization.				
Signature of Patient / Personal Representative		Printed Name	Date	
Authority if signed by Personal Representative:				
Signature of SCDMH Staff Releasing Information	Printed Name	Method of Release	Date Released	
REVOCATION STATEMENT				
I understand that I may revoke this authorization at any time, and will be asked to sign the revocation statement on this form in order to rescind this authorization. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization. "I do hereby request that this authorization to disclose health information be Rescinded"				
Effective Date Si	gnature	Printed Name	Date	
Witness Signature		Printed Name	Date	