Authorization for Release of Information

PATIENT (Last, First MI): _____ DOB: (MMDDYY) _____

SSN#: _____ GCDC Internal ID # (OFFICE USE ONLY) _____

ADDRESS: _____ JAIL ID # _____

I hereby authorize the **Greenville County Detention Center – Medical Department** to release information from my medical record as indicated below to:

NAME (Last, First MI):_____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

DAY PHONE: _____ FAX: _____RELATIONSHIP TO PATIENT: _____

INFORMATION TO BE RELEASED: TREATMENT DATES: _____

___ History and physical exam ___ Progress notes ___ Lab reports ___ X-ray reports

___Medication ___ Other: _____

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care ☐ Legal ☐ School

☐ Insurance ☐ Workers Compensation ☐ Other (please specify): _____

1. I understand that this authorization will expire on (date) _____.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand there may be applicable copying fees which I authorize funds to be debited from my canteen account for payment. (inmate)
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____ OR _____ _____

SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

_____ _____ _____

RECORDS RECEIVED BY **DATE** **RELATIONSHIP TO PATIENT**

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____