AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

325 BROAD STREET – STE 100 SUMTER SC 29150
Medical Records Phone: 803-773-5227 Ext: 2516 Fax: 803-753-0125
Email: medical.records@colonialhealthcare.com
Immunization Records Phone: 803-773-5227 Ext: 1049/1019 Fax: 803-418-0202

PLEASE DO NOT FAX RECORDS IF MORE THAN 20 PAGES.

PATIENT NAME (PLEASE PRINT)_____DATE OF BIRTH_____

ADDRESS _____ PHONE (____)_____

CITY _____ STATE _____ ZIP _____

I AUTHORIZE COLONIAL HEALTHCARE TO (CHECK ONE): ☐ RELEASE RECORDS TO: ☐ OBTAIN RECORDS FROM:

FACILITY/PERSON/SELF_____ PHONE (_____)_____

ADDRESS_____

CITY _____ STATE _____ ZIP _____

FAX (_____)_____EMAIL _____

IF TO SELF(CHECK ONE): ☐ RECORDS ON PAPER ☐ RECORDS ON CD (PDF FORMAT) ***READ NOTICE BELOW FOR FEES****

☐ I WOULD LIKE TO PICK UP MY RECORDS AT _____ (PREFERRED CFP LOCATION)

IF THE ABOVE BOX IS NOT CHECKED, RECORDS WILL PROCESSED VIA RECORDQUEST. IF LOCATION IS LEFT BLANK, RECORDS WILL BE SENT TO OUR MAIN LOCATION AT ADDRESS ABOVE. PLEASE WAIT FOR PHONE CALL TO PICK UP RECORDS. PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING, MAXIMUM OF 30 DAYS.

PLEASE CHECK ALL THAT APPLY. SPECIFY DATES IF APPLICABLE:

- ☐ IMMUNIZATION RECORDS
- ☐ ALL MEDICAL RECORDS
- ☐ OFFICE NOTES _____
- ☐ RADIOLOGY REPORTS _____
- ☐ LAB REPORTS _____
- ☐ IMAGES (PLEASE FWD TO SPECIAL PROCEDURES)
- ☐ OTHER _____

CHECK FOR RELEASE UNDER SPECIAL PROTECTION BYLAWS.

- ☐ DIAGNOSIS/TREATMENT OF AIDS, HIV TESTS
- ☐ DIAGNOSIS/TREATMENT OF DRUGS AND/OR ALCOHOL ABUSE
- ☐ CONSULTATION/TREATMENT FOR MENTAL AND/OR PSYCHOLOGICAL HEALTH CARE

PURPOSE OF RELEASE:

- ☐ REFERRAL
- ☐ SELF
- ☐ TRANSFER/CONTINUATION OF CARE
- ☐ RELOCATION
- ☐ WORKER'S COMPENSATION/INSURANCE
- ☐ DISABILITY DETERMINATION
- ☐ ARMED FORCES REQUIREMENT
- ☐ LEGAL MATTERS
- ☐ OTHER _____

UNLESS TO A MEDICAL FACILITY, THERE IS A CHARGE FOR RECORDS. *S.C. LAW, ST SEC 44/155-80* REGARDING FEES: PAPER – PAGES 1-30 $0.65 PER PAGE, PAGES 31+ $0.50 PER PAGE (MAX $200.00) $25 FOR PDF FORMAT ON CD

UNLESS REVOKED/CANCELLED IN WRITING, THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM TODAY'S DATE OR ON _____.
I UNDERSTAND AUTHORIZATION OF THIS FORM IS VOLUNTARY. I UNDERSTAND THIS FORM CARRIES WITH IT THE POSSIBILITY OF UNAUTHORIZED DISCLOSURE BY THE ORGANIZATION RECEIVING THE INFORMATION. I UNDERSTAND ALL EMPLOYEES/PHYSICIANS OF COLONIAL HEALTHCARE ARE RELEASED FROM LEGAL LIABILITY FOR RELEASE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED. I UNDERSTAND THE FEES FOR COPIES OF MEDICAL RECORDS ARE PROVIDED BY *S.C. LAW, SC ST SEC 44/115-80.*

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN/REPRESENTATIVE DATE

_____ _____
PRINT NAME & RELATIONSHIP TO PATIENT IF NECESSARY WITNESS SIGNATURE/DATE

NOTICE: EVERYTHING ON THIS FORM MUST BE FILLED OUT. IF ANYTHING IS MISSING OR INCORRECT, THE FORM WILL BE REJECTED. PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING, MAXIMUM OF 30 DAYS.

COLONIAL HEALTHCARE UPDATED: 09/2019