Authorization to Release and/or Request/Obtain Information

SECTION I To be completed by Easterseals SC

Name of Consumer (at time services were provided):		Consumer's Date of Birth:	
Address of Consumer (include zip code):			

SECTION II To be completed by requestor or person authorized to act on his/her behalf
I voluntarily authorize and request disclosure (including paper and secure electronic interchange):

OF WHAT: All my medical records; also education records and other information from Easterseals SC. This includes specific permission to release:

1. All records and other information regarding my services Easterseals SC which may include:
   - Psychological, psychiatric, or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases
   - Gene-related impairments (including genetic test results)
2. Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and teachers' observations and evaluations in Easterseals SC's records.
3. Specific Records Only:(Please list) _____

DATES OF RELEASE: This request is for records from DATE: _____ to DATE: _____

TO WHOM – Easterseals SC is authorized to release and request/obtain my records to the following named entities:

RECORDS SHOULD BE RETURNED TO:

Organization	Easterseals SC	Attention:	
Address:	PO Box 644 Fort Mill, SC 29716	Telephone #:	
Fax #:		Email:	@sc.easterseals.com

PURPOSE: Authorizing Easterseals SC the ability to release personal and confidential information to myself or my legal representative or other entities as listed above.

EXPIRES WHEN: **This authorization is good for 12 months from the date signed.**

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I may write to Easterseals SC to revoke this authorization at any time, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it.
- I understand any disclosure carries with it the potential for re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule. Easterseals SC does not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.
- Easterseals SC will give me a copy of this form when requested.

I HAVE READ THIS FORM AND AGREE TO THE DISCLOSURES OF MY RECORDS

Requestor's Printed First Name: _____ Last Name: _____ Suffix: _____

Signature of Requestor or Legal Guardian: _____ Date: _____

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; S.C. Code Ann. § 44-66-10 et seq. (Supp. 2016); and S.C. Code Ann. §44-66-75 (Supp. 2016).

Please Print/type in Black Ink