# AUTHORIZATION FOR RELEASE OF INFORMATION

From the SC Department of Disabilities and Special Needs (SCDDSN)
3440 Harden Street Ext., Columbia, SC 29203

Requestor's First Name:_____

Requestor's Last Name:_____

Suffix:_____

## SECTION I To be completed by SCDDSN

Name of Consumer *(at time services were provided)*:_____

Address of Consumer *(include zip code)*:_____

Consumer's Date of Birth:_____ Relationship to consumer:_____

## 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 SCDDSN.

This includes specific permission to release:

1. All records and other information regarding my services at SCDDSN 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).
- Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and teachers' observations and evaluations in SC Department of Disabilities and Special Needs records.

2. Specific Records Only: (Please list)

_____ _____ _____

_____ _____ _____

3. This request is for records from DATE:_____ to DATE:_____

**TO WHOM** – SCDDSN is authorized to release my records to the following named entities:

_____ _____ _____

_____ _____ _____

**PURPOSE**: Authorizing SCDDSN 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 SCDDSN 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.
SCDDSN does not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

SCDDSN will give me a copy of this form when requested.

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

_____ Date:_____

Signature of Requestor or Legal Guardian

Street
Address:

*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).*

*Return completed form to the SC Department of Disabilities and Special Needs (see above address)*
*Please contact SCDDSN with any questions at (803) 898-9706; 1-888-376-4636 (within SC only) or by email at dalston@ddsn.sc.gov*