Palmetto Pee Dee Behavioral Health is closed as of 07/2019

PALMETTO
BEHAVIORAL HEALTH SYSTEM

Palmetto Pee Dee Behavioral Health
601 B Gregg Avenue
Florence, SC 29501
843.667.0644

Authorization for Use & Disclosure of Protected Health Information

Patient name: ______________________ DOB: ____________ SSN: ________________

I hereby authorize Palmetto Behavioral Health to (check one or both) ☐ Disclosure and/or ☐ Obtain Protected Health Information with:

Name: ____

Address: ____________________________ City/State ______________________ Zip Code ____________

Phone: __________________________ Fax: ____

Dates of Service: ____

Purpose of Disclosure: ☐ Continuing Care/Treatment ☐ Family/Friend Involvement in Treatment ☐ Legal Representation ☐ Payment ☐ Educational Placement ☐ Other

The protected information to be used/disclosed is Oral (only during treatment) Written Documents (as specified below): includes: (check all that apply)

☐ Dates of Treatment	☐ Psychiatric Evaluation	☐ Nurse Assessment
☐ Diagnosis	☐ History & Physical Exam	☐ Psychosocial Assessment
☐ Treatment plan	☐ Rating Scale	☐ Nursing Progress Notes
☐ Aftercare/Discharge Plan	☐ Discharge Summary	☐ Social Progress Notes
☐ Consults	☐ Diagnostic	☐ Physician Progress Notes

☐ Other (specify) ____

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, and HIV and/or physical conditions.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under the state and federal laws (45 CFR parts 160, 164; 42 CFR part 2; 42 USC 20 odd – 3; 42 USC 290ee; SC Code Ann Section 19-11-95) and cannot be redisclosed without my further written consent unless provided for by state and federal law.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken, as stated in the Privacy Notice. If not previously revoked, this consent will expire ☐ one hundred eighty (180) days from the date of signature, ☐ date of discharge, or ☐ another date or condition specified. Other date or condition specified: ____________________________________.

______________________________ Signature of Patient   ______________ Date

______________________________ Parent/Legal Guardian Signature   ______________ Date

______________________________ Signature of Witness   ______________ Date

A fee for records may apply when records are released not related to treatment, payment or health care operations. Payment must be received prior to release of records when payment is required.

RECORDS NOT ROUTINELY FAXED EXCEPT FOR NECESSARY CONTINUING CARE

Custodian of Records for closed facilities:

Universal Health Services-Nashville Regional Office
Phone: 615-312-5834 Fax: 615-997-1200 Email: nrorecordsrequests@uhsinc.com

To prevent delay of processing your request, please include a copy
of a government issued photo ID (i.e. a driver's license) for verification of signature.