SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Beneficiary Information

Beneficiary Name: _____
Last *First* *M.I.*

Beneficiary Date of Birth: _____ Medicaid ID: _____

Authorization and Description of Information to be Released

I, _____ hereby authorize the South Carolina Department of Health and Human Services
Beneficiary Name or Legal Representative

to release specific health information from the records of the above named beneficiary for the specific purpose of: _____

_____

Specific information to be disclosed: _____

Recipient (person or organization that will receive your information)

Recipient: _____

Phone Number: _____ Email: _____ Fax Number: _____

Address: _____
Street Address/P.O. Box *City* *State* *Zip Code*

I understand that this authorization will expire on the following date, event or condition: _____
Expiration Date, Event or Condition

I understand that if I fail to specify an expiration or end date, event or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time by completing the Revocation Form located on the South Carolina Department of Health and Human Services website and submitting the completed Form to: Privacy Official, Office of Civil Rights and Privacy; SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206. I further understand that any action taken on this authorization before submission of the Revocation Form is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without any further written authorization unless otherwise provided for by state or federal law.

_____ _____
Signature of Beneficiary *Date*

_____ _____
*Signature of Legal Representative** *Date*

*Documentation of the authority to act as the legal representative for the beneficiary must be attached.