

**South Carolina Department of Health and Human Services (SCDHHS)
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

<i>For Office Use Only – TO BE COMPLETED BY SCDHHS</i>		
Applicant/Beneficiary Name	<i>(First)</i>	<i>(Middle)</i>
	<i>(Last)</i>	
Social Security No.	Date of Birth	Household No.

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW. ****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

WHAT All my medical records, education records and other information related to my ability to perform tasks.
This includes specific permission to release the following:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
 - 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. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc., including mental health, correctional, and addiction treatment and Veterans Administration health care facilities)
- All educational sources (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SCDHHS/SCVRD (as needed) for additional information to identify the subject (e.g., other names used), the specific source or the material to be used.

TO WHOM The State agency authorized to process my case (usually called "SCVRD"), including contract copy services, doctors, or other professionals consulted during the disability determination process.

PURPOSE I agree to the disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits.

EXPIRES WHEN This authorization is binding for 12 months from the date signed below.

I UNDERSTAND THAT

- I may write to the South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where this information may be re-disclosed to other parties directly involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

Please complete the following using Black or Blue ink

Signature of Applicant/Beneficiary (or Person Authorized to Act on His/Her Behalf)	Relationship to Applicant/Beneficiary	Date
Street Address	City	State Zip
		Telephone No. ()
Signature of Witness (If signed with an "X")	Date	Signature of Witness (If signed with an "X")
		Date

**AUTHORIZATION FOR RELEASE OF INFORMATION TO THE
SC VOCATIONAL REHABILITATION DEPARTMENT (SCVRD)**

We need your written authorization to help get the information required to process your application for benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing Form 921. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. Some sources of information require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to the South Carolina Department of Health and Human Services, Bureau of Eligibility Policy and Oversight, P.O. Box 8206, Columbia, S.C. 29202-8206. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. SCDHHS can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SCDHHS to decide your claim.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SCDHHS/SCVRD is protected by the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Business Associate agreement signed between SCDHHS and SCVRD. In addition, SCDHHS/SCVRD retains personal information in strict adherence to the State regulations 19-903, 19-933, 19-963, and 19-983.

We use the information obtained with this form to determine your eligibility for benefits. In some cases, your information may also be reviewed by SCDHHS personnel and contractors that process your appeal of a decision and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim and could result in denial or loss of benefits.