Greenville ADHD Specialists

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AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete this form in order for Greenville ADHD Specialists to obtain information from or release to another provider (i.e. primary care physician, therapist, counselor, school, testing center, etc.).

Patient Name: _____ **Date of Birth:** _____

Previous Name (if used in records): _____ SSN (last four digits) _____

I authorize Greenville ADHD Specialists to **RECEIVE my information FROM and/or RELEASE my information TO** the following person or organization.

Name of Individual/Organization:			
Address:	City:	State:	Zip:
Phone:	Fax:		

INFORMATION TO BE RELEASED (Please check all that apply for the person or organization listed above):

Healthcare / Clinical:

- ☐ Encounter Notes (Past 12 months or last visit)
- ☐ Lab Reports
- ☐ Sleep Study Results & Notes
- ☐ Well Checks (Last 2 visits)
- ☐ Growth Charts (for age 12 or under)

Mental Health / Behavioral:

- ☐ Mental Health / Therapy Notes (Initial visit and last 2 visits)
- ☐ Psychological Evaluation / History
- ☐ Treatment Plans
- ☐ Discharge Summary

School / Learning Center:

- ☐ Psychological or Educational Tests
- ☐ IEP (Initial and latest follow-up)
- ☐ Plan 504 (Initial and latest follow-up)
- ☐ Discipline Referrals (Last 12 months)
- ☐ Suspensions (Last 12 months)
- ☐ ADHD/Behavioral Notes

☐ Other (please describe): _____

PURPOSE/USE OF REQUESTED INFORMATION:

- ☐ Sharing with other health care providers
- ☐ Personal use by patient
- ☐ Other (please describe): _____

I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.

I hereby, knowingly and voluntarily authorize Greenville ADHD Specialists to use or disclose my health information in the manner described above and my authorization will remain effective from the date of my signature until revocation. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Greenville ADHD Specialists' Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing. I understand that if the authorized recipient of this information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be no longer protected by these regulations and may be re-disclosed. I release Greenville ADHD Specialists from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Printed Name of Patient or Legal Guardian | Relationship to Patient (if signed by Legal Guardian)

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