Carolina Therapeutics

Authorization to Disclose Protected Health Information

HIPAA Release

I, _____ (patient/parent/legal guardian), hereby authorize the receipt/disclosure of information, records or billing of the above-named patient to: Carolina Therapeutics, PLLC, 1698 Hwy. 160 W., Ste. 240, Fort Mill, SC 29708, phone: 704-654-8599, fax: 980-938-6088.

- For the specific purpose(s) of: Any purpose deemed appropriate by my treating clinician(s) at Carolina Therapeutics, PLLC, including but not limited to treating or diagnosing any disease or condition, whether mental or physical.
- Specific information to be disclosed: Any and all information which may be requested by my clinicians at Carolina Therapeutics, PLLC, me, my parent, legal guardian, spouse, attorney, or personal representative, including but not limited to, my educational records, enrollment forms, intake documents, disciplinary documents, evaluations, IEP notes, incident reports, medical/health records or insurance claim materials in your possession, custody, and control, and if necessary, to allow all persons or entities stated herein or anyone appointed by them, to examine these records, or any records containing medical records, medical notes, or medical bills which you may possess regarding my education, physical or mental health conditions, healthcare, or treatment.

I understand that this authorization will expire in the event or condition when either I, or an authorized legal guardian, or spouse revokes this authorization in writing. I also understand that I may revoke this authorization at any time.

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 my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I, _____ (patient/parent/legal guardian), hereby authorize to release/receive confidential treatment information and records regarding:
_____ (patient name) and Date of Birth: _____.

Name\Facility	Address	Phone #	Fax #

I understand that I may revoke this consent at any time by informing in writing, except to the extent that action had already been taken in reliance on it. In signing this consent, I hereby release the above parties from any and all liability arising there from.

Acknowledgement
I, _____ (patient, parent, legal guardian), have read and understand the policies stated above, and I agree to the terms as stated.
Signature:
Date: