SC Professional Services, LLC
d/b/a Hope Integrative Medicine
775 Saint James Avenue, Suite B
Goose Creek, SC 29445
Phone: 843.779.7718

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

I understand that my medical record may contain sensitive information regarding mental health, drug or alcohol abuse, HIV/AIDS status, or other confidential information. With this understanding, I hereby waive any right to confidentiality arising under South Carolina law and authorize the release of records of information, but only the extent specified below.

I authorize **Hope Integrative Medicine** to release and/or receive the following information:

☐ All Medical Records
☐ Diagnosis
☐ Presence/Participation in Treatment
☐ Other:

The above information is only to be released to, and/or from, the following party:

_____

Name and/or Agency Address City, State, Zip Fax or Email

This information is to be used for the purpose of continuity of care.

This authorization shall remain in effect for 1 year at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

Patient Signature: _____ Date: _____