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

Release of Medical Information

I, _____, direct Hope Integrative Medicine to disclose my protected health information described below to:

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Please circle one: Home Cell Work

Email: _____

Health Information to be disclosed upon request of the person above:
(Check either A or B)

A. Disclose my complete health record (including but not limited to diagnoses, lab test, prognosis, treatment, billing and appointment dates and time) OR
B. Disclose my health records, as above, BUT DO NOT Disclose the following information (check all appropriate)
   - ☐ Mental Health Records
   - ☐ Communicable Diseases (including HIV and AIDS)
   - ☐ Other (please specify):

_____

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ Hard Copy
- ☐ Other: _____

This authorization shall be effective until (check one):

- ☐ All past, present and future periods, OR
- ☐ On this Date or in the event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider in writing.)

_____ _____
Print Name of Person Giving This Authorization Date of Birth

_____ _____
Signature of Individual Giving This Authorization Date

_____
Staff Initials

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524