



SC Professional Services, LLC
d/b/a Hope Integrative Medicine
1064 Gardner Road, Suite 215
Charleston, SC 29407
Phone: 843.737.0312

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
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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: _____