



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