Medical Records Release

(1) (Name of provider and/or insurer) _____ can disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ ID Number: _____

The records cover the period(s) of health care related to this request for external review.

(2) Information to be disclosed:

Health information, including medical records, relating to this request for external review.

I understand that this may include information relating to (check if any apply):

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection.

_____ Psychiatric Care

_____ Treatment for alcohol and/or drug abuse

(3) This information will be disclosed to the Independent Review Organization (IRO). This information will only be used for this external review.

(4) I can withdraw this release at any time. I must do that in writing. I understand that information may already have been disclosed. Without these records, the covered person will not get an external review. Otherwise, this release will end when the external review ends.

Signature of Patient: _____ Date: _____

or Legal Representative: _____ Date: _____

If the covered person has any questions, contact the South Carolina Department of Insurance by writing or calling:

Consumer Services Division
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180 or
1-800-768-3467