Instructions for filling out Disclosure of Information Form

Print your name (if your last name has changed, please enter your name at the time you were a patient at Shriners)

Enter Date of Birth and address and telephone number

#1 – enter the name and the full address where we will be sending the information. If it is going to you, you can put “self”

#2 – check off the specific information that you are requesting, for example – discharge summary or progress notes, etc. If you are sending information to another health care provider, they rarely need your entire record. Usually just last few H&P’s, last few surgeries or last few progress notes. If information you need is not listed, then write it in next to “other”.

#3 – enter the reason for the request – personal, legal, other healthcare provider, etc.

#4 – if any of the items listed pertain to your records, please check off and sign.

At the bottom, there is a place for a witness to sign – this can be anyone (friend, family, co-worker) it does not need to be notarized.

Then you can sign and date on the appropriate line(s) at the bottom.

If the patient is currently between ages 14 and 17, they must also sign the form along with the parent/guardian.

If you are 18 or over and requesting your record, you must also send a copy of your driver’s license along with this form.

You can fax the completed form (along with copy of ID if necessary) to the fax # on the form. Or you can mail it to the address on the form.

Fees for copying/mailing records

If the patient/parent/guardian is requesting copies of medical records for personal use, there is a fee. We will notify you of fees before copying the medical record for you.

Fees for Shriners Hospitals for Children, Greenville are as follows:

0.65 first 30 pages and 0.50 per page after that copy fee.
$25 X-Ray Disk Gait lab video $10

There is no fee for records requested to be sent to another healthcare provider.

If you have any further questions regarding completing this form, please call us: 864-240-3107

1/13/15
Authorization for Disclosure of Health Information

Patient Name: ____________________________  Medical Record #: ______________  Date of Birth: ______________

Address: ________________________________________________________________

Telephone: ______________________________________________________________

For the period(s) of health care from (date) ____________________ to (date) ____________

1. I hereby authorize Shriners Hospitals for Children, Greenville to disclose to:

Name: ________________________________________________________________

Street Address: __________________________________________________________

City, State & Zip Code: ____________________________________________________

Shriners Hospitals for Children
950 W. Faris Rd
Greenville, SC 29605

Phone  864-240-3107    FAX  864-240-3113

2. Information to be disclosed:

- Discharge Summary
- History & Physical examination
- X-ray reports
- Billing Statements
- Progress Notes
- Laboratory tests
- X-ray films/images
- Other
- Operative Reports
- Consultation reports
- Photographs/slides
- MAL

3. Reason for disclosure: __________________________________________________

4. Separate signature required for release of information related to items below. Initial each line if required.

- Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- Behavioral health services/psychiatric care/psychotherapy records
- Alcohol and substance abuse diagnosis and treatment records
- Pregnancy, contraceptives, and sexually transmitted diseases
- Genetics testing

Signature for release of information in item 4: ________________________________

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has
   Been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in one
   Year (12 months) from the original date for release of information to family members: six (6) months
   From the original date for all other releases.

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been
   answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, its successors and
   assigns, and its agents and employees, from and against any claim or cause of action based on the release
   of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way
   To prevent this re-disclosure and cannot be held liable for such re-disclosures.

☐ I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign
   will not affect my child’s or my treatment or ability to receive treatment at Shriners Hospitals for Children.

Witnessed by: ____________________________________________________________

Signature of Father or Legal Guardian: ________________________________________

Date: ________________  Signature of Mother or Legal Guardian: _______________________

Signature of Patient (if 14 years of age or older): _________________________________