Fetter Health Care
NETWORK

51 Nassau Street
Charleston, SC 29403
Phone (843) 722-4112
Fax (866) 285-7156

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Full Name (print): _____ **Date of Birth:** ____/_____/_____

Last 4 of SS#: _____

Fetter Health Care Network, Inc. is hereby authorized to release or receive confidential information to/from the following agency or individual (please list to include name, phone #, fax # and address of agency, family member or individual below**):**

Name_____Relationship_____Phone/Fax Number: _____

Name_____Relationship_____Phone/Fax Number: _____

Name_____Relationship_____Phone/Fax Number: _____

Information may be received and given in the following form (please check all that are allowed):

☐ Written Documentation	☐ Audio	☐ Video
☐ Electronic	☐ Verbal	☐ Other

Initial	Expiration Date	Permission to Release the Following:
		I hereby waive any psychiatrist-patient and/or psychologist-patient privilege with respect to information released to the above-named individual or agency.
		I hereby waive any privileges concerning records of infectious or contagious disease, including TB, STD, HIV/AIDS confidential information with respect to records released to the above name individual or agency.
		I hereby waive any privileges concerning records of drug or alcohol abuse and/or treatment or mental health treatment with respect to records released to the above name individual or agency.
		I hereby consent to the release of information for case management services related to discharge planning and social services benefits.
		I hereby consent to the release of all healthcare information for primary care services related to diagnosis, treatment, evaluation, and follow-up. _____
		I hereby consent to the release of healthcare information ONLY related to the following diagnosis. Please specify diagnosis or state not applicable. _____
		I hereby consent to accepted detailed appointment reminders via phone, email or text messaging using the information filed with the health center.

I hereby release Fetter Health Care Network, its officers, agents and employees from any and all liabilities, damages and claims which might arise from the release of information authorized above. I understand that signing this form is voluntary and that if I do not sign, it will not affect the quality of my treatment at FHCN. If I change my mind, I understand that I can withdraw this authorization by providing a written notice of withdrawal. The withdrawal will be effective immediately upon my health care provider's receipt of my written notice, except that the withdrawal will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of withdrawal.

I acknowledge that this consent for release of protected health information is valid one year from the signing date unless otherwise stated above.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Witness Signature Date