AUTHORIZATION TO REQUEST/RELEASE INFORMATION
GREENVILLE COUNTY PROBATE COURT COMMITMENT DIVISION

Name of Person Alleged to be Mentally Ill, Chemically Dependent or a Child in Need of Mental Health Treatment, Person with Mental Retardation:

_____

Is this person a child 16 years of age or older? Yes_____ No_____
(A child 16 years of age or older may sign this authorization himself/herself.)

Patient's Address: _____ SS No.: _____

_____ Patient's DOB: _____

The purpose of the release is to: _____

I hereby authorize the Commitment Division of the Greenville County Probate Court to release the following information from the court file of the above-named person to:

Name: _____
Address: _____
_____
Telephone No.: _____

Relation to the person whose name appears on the first line of this form:_____

PORTION OF THE COURT FILE TO BE RELEASED*:

_____ Affidavit & Application for Involuntary Emergency Admission for Chemical Dependency and Physician's Certification
_____ Affidavit & Application for Involuntary Emergency Hospitalization for Mental Illness and Physician's Certification
_____ Affidavit and Petition for Involuntary Judicial Admission for Chemical Dependency
_____ Petition for Judicial Admission (Mental Illness)
_____ Application for Child in Need of Emergency Admission and Physician's Certification
_____ Petition for Judicial Admission of a Child
_____ Notices Regarding: Initiation of Proceedings, Hearings, Appointment of Examiners, Dates of Examination
_____ Notices Regarding Supplemental Proceedings
_____ Designated Examiner Reports
_____ Court Documents from Proceedings to Involuntarily Admit a Person with Mental Retardation or Related Disability to the Services of the Department of Disability and Special Needs (DDSN), pursuant to §44-20-450 of the S.C. Code
_____ Court Order(s)
_____ Other (please list): _____

*The Court will not release copies of any medical records that may be in its files. Those records must be requested directly from the facility where the person was or is being treated.

Date(s) for which Court documents are requested: From_____ to_____

You may withdraw this consent at any time by written notification to the Court, provided action has not been taken in reliance upon this authorization. Individuals will not be charged for copies of their own records, nor will an attorney or guardian representing the person. All others will be charged for copies at the per page rate in effect at the time of the request.

I AM AWARE THAT WHEN THE DOCUMENTS IN MY/THE PATIENT'S COURT FILE REFLECT INFORMATION CONCERNING PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, AND/OR ALCOHOLISM, AND/OR INFORMATION REGARDING HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND OTHER INFECTIOUS DISEASES, THAT THIS INFORMATION WILL BE RELEASED AS PART OF MY COURT FILE, IF CONTAINED IN THE REQUESTED DOCUMENTS.

_____ **(Initials) INFORMATION DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT AND NO LONGER PROTECTED BY THE FEDERAL PRIVACY REGULATIONS**.

_____ _____
DATE PATIENT'S SIGNATURE

THIS RELEASE EXPIRES 60 DAYS FROM THE DATE SIGNED BY THE PATIENT

SWORN to before me this ____ day of_____, 20____ _____

AUTHORIZED PERSON / RELATIONSHIP

_____
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: _____

NOTE: The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form is protected by State or Federal laws and will authorize release of the information specified. All items must be completed. If the information is not complete, we may not be able to comply with your request.

STATUTORY REFERENCES: §§44-23-1100 and 44-22-100 of the S.C. Code, and 42 C.F.R. Part II