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MCLEOD REGIONAL MEDICAL CENTER

The Choice for Medical Excellence

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Created 2015 Reviewed 12-4-2018; 3-23-21 Revised 12-4-18; 2-19-2020; 3-23-21; 5-26-22, 7-27-23

Patient Name: _____ Date of Birth: _____
Address: _____ Employee ID # _____
Patient# or MR#: n/a

Advanced Practice Mental Health & Wellness of SC

I authorize _____ to use or disclose my "protected health information" (PHI)

to: McLeod Employee Assistance Program, 800 East Cheves Street, Suite #320, Florence, SC 29505

Recipient Name	Address	City	State	Zip

30 days after closing of acct.

Information for treatment period: From (date) _____ To (date) _____

- Discharge Summary
- Pathology Reports
- Operative Notes
- Other (please specify: Case consultation and coordination of care)
- 42CFR (Substance Abuse)
- History and Physical Examination
- Laboratory Tests
- Emergency Department Reports
- Consultation
- Radiology Reports

Purpose(s): Legal Investigation Insurance Disability Determination Other

OR: I request my information be released to me to exercise my right to access and obtain a copy of my PHI.

- A.) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
- B.) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).
- C.) I understand I may revoke this Authorization at any time however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation process.
- D.) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
- E.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.
- F.) I understand that this Authorization will expire in 90 days after it is signed unless another date is specified here _____.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

_____ Print Patient Name	_____ Patient Signature	_____ Date
_____ Authorized Representative	_____ Relationship to Patient	_____ Telephone Number

PROVIDER USE ONLY: Received on _____ Disclosure on _____ Copy to Patient on _____
Disclosure by: _____ Authority: _____

McLeod Health

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Employee Assistance Program Intake Form

Date _____

Client Full Name: _____
(First Name - MI - Last Name)

Home Address: _____ City/State/Zip: _____

Birthdate: _____ Age: _____ Sex: _____ SS# _____

Home #: _____ Work #: _____ Cell #: _____

Education: _____ Ethnic background: _____ Marital Status: Married/Divorced/Sep/Single/Widow

Email Address: _____

Client is: Employee Spouse Dependent

Employee's status: Full-Time Part-Time PRN

How did you learn about the EAP? _____ Referred by: _____

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Insurance Company: _____ Insured's SS# _____

Policy/Member #: _____

EMPLOYEE INFORMATION

Employee name (if different from above) _____ DOB: _____

Which company do you work for? (Check one below)

McLeod _____ / McLeod Campus: _____ / McLeod Employee ID# _____

Charles Ingram Lumber _____	City of Florence _____	CareSouth _____	Chester/Marlboro _____
Florence Reg Airport _____	Housing Author _____	McCall Farms _____	Vulcraft _____
Ruiz Foods _____	SteelFab _____	Trinity BH _____	MPD _____

Department/Job Title: _____ Work Phone: _____ Hire date: _____

Created: 8/23/22

Revised: 6-12-23; 3-28-24; 6/26/24; 1/13/26; 2/10/26; 3-12-26

Special Situations

Health Oversight Activities – We may make known your health information to a government agency, such as DHEC, for health oversight activities such as inspections or to give a license to the people who treat you at McLeod. These activities are necessary for the government to monitor the health care system, programs and to obey the laws.

Lawsuits and Law Enforcement – We may make known your health information to answer a court order or search warrant. We may also answer a subpoena but only if efforts have been made to provide you the option to object and obtain a court order to protect the information. Subject to certain conditions, we may make known your health information for a lawful purpose if asked by a law official such as locating a suspect.

Coroners, Medical Examiners and Funeral Directors – We may make known your health information so they may carry out their duties.

Minors – McLeod will obey the South Carolina law about minors. We may give out certain types of your health information to your parent or guardian if it is needed by law.

Specialized Government Functions – We may give out your health information to obey military and veteran rules; for lawful security activities or to provide protection to the President. We may make known the health information of an inmate or person in custody to a correctional institute or law official to provide health care or to protect their health and safety or the health and safety of others.

Organ and Tissue Donation – If you are an organ donor, we may release your health

information to organizations that handle the donation process.

Public Health – We may make known your health information for public health purposes. Examples include: to prevent or control disease, injury or disability; to report births; or to report drug reactions.

Workers' Compensation – We may make known health information about you for workers' compensation or similar programs.

Food and Drug Administration (FDA) – We may make known your health information to help fix food, drug, supplements and medical equipment problems.

Other Uses and Disclosures

Business Associates – We may disclose your health information to our business associates that perform functions on our behalf or provide us with services to help take care of you. The business associate must keep your information safe and secure.

Those who help take care of you – We may use your health information to tell a family member or other person involved in your care about your care, location and general condition. This will be done by the best judgment of the people who gave you care at McLeod Health, unless you object.

Right to Change Practices

We have the right to change these practices about protected health information that we create and/or maintain. The revised practices will be posted on the website and in our buildings near the registration desk.

McLeod Health

The Choice for Medical Excellence

Notice

Of

Privacy

Practices

**THIS NOTICE DESCRIBES
HOW MEDICAL
INFORMATION ABOUT YOU
MAY BE USED AND
DISCLOSED AND HOW YOU
CAN GET ACCESS TO THIS
INFORMATION. PLEASE
REVIEW IT CAREFULLY.**

Effective Date 4-13-03

Effective Revision Date 09-16-13

Our Promise

It is the policy at McLeod Health to protect the privacy and integrity of its patients' protected health information. This is required by law and by ethics. All of the people who work for McLeod Health must follow the rules found in this Notice of Privacy Practices.

Your Health Information

Each time you are a patient of McLeod Health a record of your care is made containing health information that is protected. We are allowed to use and to make known this protected health information:

- To provide treatment and care to you. An example is ordering a lab test.
- To receive payment for taking care of you. An example is sending a bill to your insurance company.
- To manage McLeod Health. An example is to participate in an inspection.
- To obey the law. An example is to record birth certificates.

We must obey the law:

- To keep your protected health information private by following the legal rules;
- To give you this Notice of our legal duties and privacy practices with respect to your protected health information;
- To follow the terms of this Notice that are currently in effect.

Your Privacy Rights

Although your health record belongs to McLeod Health, the information in the record belongs to you. With a written request you can:

- Review and ask for a paper or electronic copy of the health information in your

medical and billing records, there may be a fee.

- Ask that information be added to your record if you feel there is an error,
- Ask to know to whom your health information was made known to outside of those taking care of you,
- Ask that certain people not be allowed to see your health information,
- Ask that we get in touch with you about your health information in a different manner than we normally do,
- Ask for a paper copy of this Notice of Privacy Practices at any time, and
- Change your mind on allowing us to use or give your health information after you have given your permission.
- Be notified when your unsecured information is lost, stolen or used by an unauthorized person.
- Ask to not bill your health plan if you paid for an item or service in full and out of pocket. We will honor this request.

McLeod Health does have the right to say no to a request and will try to work with you so that your needs can be met.

Using Your Health Information

We may use and make known your protected health information without your OK:

- For treatment, payment or to manage McLeod Health,
- To tell you of health services, treatment options and health-related benefits,
- To remind you of an appointment,
- For our hospital directories using only your name, room number, one-word condition and religion,
- To those involved in your care or the payment of your care, unless you object,
- To notify family or friends of your location in the event of a disaster, unless you object,

- To raise money however you may opt out of receiving communications about fundraising at any time,
- For certain types of research, As needed by law,
- To send out data breach notices,
- To stop something that might harm someone's health and safety,
- To use an electronic exchange to share your patient data for treatment, payment or to manage the hospital, unless you object.
- For special situations involving health oversight activities, lawsuits and law enforcement, coroners, medical examiners and funeral directors, minors, the military and veterans, national security, intelligence activities, organ and tissue donation, public health, workers compensation and the Food and Drug Administration.

Your health information will not be used or given to anyone for any other reason unless you say it is all right. This is especially true for certain uses and disclosures or psychotherapy notes, for marketing purposes or for disclosures that can be the sale of your information. We will also stop using or making known your protected health information after we have received a written request from you to do so. You understand we can not take back information we have made known and must continue to obey the laws.

File a Complaint

If you think there has been a problem with your privacy rights you may file a complaint with the Corporate Compliance Officer at 777-8097, or the Compliance Hot Line at 1-888-679-3531 or with the Secretary of the Department of Health and Human Services. You will not get in trouble for filing a complaint nor will treatment be withheld from you.