Authorization To Disclose SCDMH Protected Health Information-SBIRT Referral Only

I, _____ , at _____
(Name of requestor) Address (Street, City, State, Zip)

DOB _____ , SS# _____ , Medical Record # _____ authorize the release of my

SCDMH health information, as specified below, for the following purpose:

"SBIRT (Screening, Brief Intervention and Referral to Treatment) Referral Disclosure: Under the SBIRT Project, the South Carolina Department of Health and Human Services has engaged collaborative partners to promote healthy outcomes for Medicaid pregnant women through integrated screening, brief intervention and referral to treatment for cessation of tobacco use, alcohol and other drugs, domestic violence and emotional health. The South Carolina Department of Mental Health (SCDMH) may receive referrals from Medicaid enrolled providers for Medicaid pregnant women who screen positive on the Integrating Screening criteria for emotional health and who meets SCDMH's inclusion criteria for treatment admission. As a result of the referral, the SCDMH will make a determination for individual admission and mental health treatment intervention and provide the specified patient information below to the SBIRT provider for referral purposes only.

I authorize the release of the following information for the time period from: _____ to _____ .

Reporting Month: _____	**This information should be released to:**
Client Medicaid Number: _____	
Reported Weeks of Pregnancy: _____	**Name:** _____
Date of SBIRT Referral: _____ (date received from MHN/MCO)	**Address:** _____
	_____
Admitted for Treatment ☐ Yes ☐ No	**Telephone No.:** _____
Date of Treatment Admission: _____	**Relationship:** _____
Refused Treatment: ☐ Yes ☐ No	
Referral Entity for Information Release: _____	

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

_____

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

_____

I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

_____ _____ _____
Signature of Individual/Personal Representative Printed Name Date

Authority if signed by Personal Representative _____

_____ _____ _____ _____
Signature of SCDMH Staff releasing information Printed Name Method of Release Date Released