

STATE OF SOUTH CAROLINA)
COUNTY OF _____)

AUTHORIZATION FOR THE
RELEASE OF RECORDS

TO:

ADDRESS:

I am currently involved in a family court matter in which Hollie S. Bennett, LBSW has been appointed as my child's Guardian *ad Litem*. I understand that in order for Hollie S. Bennett, LBSW to complete his/her duties, he/she must have complete access to the records which are currently in your or your office's possession. I am hereby authorizing you to release to Hollie S. Bennett, LBSW for his/her use, copies of any and all records which you may have on me or any of my children. I hereby waive any privilege accorded to me under the law, or which may exist under recognized privilege, such as patient- doctor.

I also authorize Hollie S. Bennett, LBSW to make any and all use of these medical and/or other records, and he/she may produce the same to whom and as he/she sees fit.

I also authorize you or the appropriate people on your staff to talk to Hollie S. Bennett, LBSW or anyone on his/her staff, either face-to-face, by telephone, or by way of correspondence about my treatment or my child's treatment.

By this release I hereby waive any privacy accorded to me under federal law as it pertains to drug and/or alcohol addiction treatment.

HIPAA Certification:

Pursuant to 45 CFR 164.512, I certify that by accepting this release, I have had proper notice under HIPAA, that I request pursuant to HIPAA that you release the information noted above, and that this release contemplates that the documents you release may be used by the recipient of the records for all purposes permitted by the Federal or South Carolina Rules of Appellate and Civil Procedure and the Federal or South Carolina Rules of Evidence.

I hereby waive any rights under the Freedom of Information Act.

Date: _____

Date of Birth: _____

Sex: _____

Social Security Number: _____

Witnesses:

