AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose

For you to authorize the disclosure of your personal information, which may include health information, to persons or organization outside of the South Carolina Department of Veterans' Affairs (SCDVA). Your privacy is protected by state and federal privacy laws. As such, SCDVA needs your explicit permission to make the requested disclosure. Please complete each section of this form.

Your Name and Identification Information

Name _____

Address _____

City _____ State_____ Zip Code_____

Telephone (____)_____ E-mail Address _____

Date of Birth_____

What personal information, including health information, is SCDVA to disclose?

1. All Information: Yes ☐ No ☐

2. Other: Yes ☐ No ☐. If "yes," please describe in detail the type of information that SCDVA is allowed to disclose. (If your description under this selection is not sufficiently clear, SCDVA will withhold the requested information if deemed "private" under the law, unless otherwise legally required to release it.)

_____

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To whom is SCDVA authorized to disclose your personal information?

Please state the name of the individuals or organizations, including contact information.

_____

_____

_____

Indicate the duration of this authorization.

Indefinitely ☐

or

Specified Date ☐_____(month/day/year)

Right to Revoke

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice, including e-mail notice, to SCDVA contact below. Any disclosure of personal information, including health information, which SCDVA may have made under this authorization prior to revocation will not be affected, as they were made while this authorization was still in effect.

Further Disclosure

Once SCDVA discloses your personal information, including health information, to the above persons/organizations, the information may no longer be protected under state or federal privacy laws. SCDVA cannot control what these persons/organizations do with your information.

Signature

I, _____ (print name), have read and understand the contents of this authorization. I also understand that I am under no obligation to sign this authorization. Accordingly, I authorize SCDVA to disclose my personal information, including health information, to the persons or organizations I have identified above.

Signature _____ Date _____