DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/FOIA	7-11-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000012	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Cok Cleared 7/16/13, letter attached	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 7-25-13 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Stratos Legal Records, LLC

4299 San Felipe, Ste. 350
Houston, TX 77027
713-375-0121 FAX: 281-200-0830

VIA: [ ] MAIL [ ] FAX: COVER AND ____ PAGES

CUSTODIAN OF RECORDS
South Carolina Medicaid
1801 Main Street
P.O. Box 8206
Columbia, SC 29202.
Main: 803-898-2795 **Fax: 803-255-8338**

Please find enclosed a request for records of:

Kendra Kastasia Silk
DOB: 06/17/2010 SSN: 503-45-0726

We are requesting:

ANY AND ALL MEDICAID RECORDS, pertaining to Kendra Kastasia Silk, DOB: 06/17/2010, SSN: 503-45-0726, including but not limited to medical records, disability records, any records reflecting benefits applied for and received, any records reflecting benefits applied for and denied, claims history records, office notes, any type of report, any type of correspondence, and anything else reduced to writing in the possession, custody or control of the said witness, and every such record to which the witness may have access

IF RECORDS ARE STORED ELECTRONICALLY, PLEASE FORWARD ON CD. (Per the HITECH ACT)

Please call to confirm you have received our request. We will call you within 3-5 days for a page count and fee approval. IF YOUR FEES EXCEED $100.00, please call for approval before sending records. **Please have records sent by fax to (281)200-0830 or mailed to the address above.** If approval is not given or if an invoice is not sent with the records, we **WILL NOT** be responsible for charges. Thank you for your cooperation.

We need these records and legal documents returned **BEFORE:** _____.

Contact: Harmony Trevino

Order No. 56928.001

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: Kendra K. Silk	Date of Birth: 6·M·2010
Address:	SSN: 503450726
City:	Reason for Disclosure: Legal
State:	Recipient of Records
Zip code:	Stratos Legal Records, LP 4299 San Felipe Suite 350 Houston, Texas 77027
Telephone #:	

I, Kendra K Silk (Patient full name), hereby authorize South Carolina Medicaid (Name of medical care provider) to release and disclose all protected medical information from ANY (Dates of treatment) to PRL for the purpose of review and evaluation in connection with a legal claim.

I expressly request that the provider listed above disclose to the Recipient named above, full and complete protected medical information including any and all of the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor notes, and records received by physicians.
- All autopsy, laboratory, histology, cytology, pathology, CT scans, PT scans, MRI, echocardiograms and cardiology reports.
- All original pathology blocks and/or slides.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CD's/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills and insurance records.

I understand that this information released may include treatment for physical and mental illness, alcohol/drug abuse, the presence of a communicable or non communicable disease and/or HIV/AIDS test results and diagnosis. This consent is subject to revocation in writing at any time by mailing the revocation to the above named Recipient. Any revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by the Recipient. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the Recipient and may no longer be protected by the federal privacy law. I understand that my health care, payment for health care and eligibility for benefits or enrollment will not be affected by whether or not I voluntarily sign this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records and materials requested herein.

This authorization and consent will expire in one year from the date of authorization written below.

WildFlowerSilk — Signature of Patient/Parent or Legal Guardian*

mother — Relationship if not Patient

WildFlowerSilk — Printed Name

7/10/2013 — Date Signed

* If signature is other than Patient or Patient's parent (if patient is under 18) a copy of the legal papers verifying authority (i.e. estate administrator, appointed executor or power of attorney) must accompany this authorization when presented.

South Carolina Department of
Health & Human Services

Anthony E. Keck• Director
Nikki R. Haley• Governor

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		$_____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Finance and Administration
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-3202 • Fax (803) 255-8235

Log # 000012

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

July 16, 2013

Mr. Harmony Trevino
Stratos Legal Records, LLC
4299 San Felipe, Ste. 350
Houston, TX 77027

Re: Records for Kendra Kastasia Silk

Dear Mr. Trevino:

Thank you for your courtesy in providing the Authorization for the Release of Medical Information. After a search of our records, it appears that our system does not have any beneficiary with the name, Kendra Kastasia Silk, nor the social security number supplied in your request.

If you can supply us with different identifiers, we will be more than happy to search our system again. If you have any questions, please contact me at the address below or call (803) 898-2794.

Sincerely,

Linda Hillian

Linda Hillian
Paralegal

/h

Office of General Counsel
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 898-4515