11-24-16

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NOV 30 2016

S.C. SUPREME COURT

To: Supreme Courts of South Carolina

Pittioner: Kendall M. Baccus

Hello my Case is currently in review with your courts. However I Have more additional information Pretaining my Case For Relief. Okay as of my pro-SE Im aurging That my lawyer Mr. William E. Grove was ineffective on my Behalf For Failing To see if I actually was compented Enough To stand a Trial or Plea deal Due To my Mental Health illnesses. Which I am mentaly ill and Have Been Bringing That up since The charge occured! Even in my incentdint report officer stated He did not understand me at all, As if I was [illegible] on drugs or mentally ill. Then I reported To my lawyer of my state of mind and feel as Though I should Be examine By an doctor Before we go any further in my case. He stated Thats no need. He Himself stated on The record, He Thought I'd gotten advise from another Inmate To Request That. Which isn't The case I Have Been mentaly ill my entire life nearly. Seeking Help is what I've wanted always. He over looked That Fact and Co-Heersed Me Kendall Baccus Into Pleaing guilty That I'd get an lesser Sentence and mis-lead me into a system which He knew I knew nothing about. Im sending all my files my records To your Courts Showing my mental Health State and proof That I Have plead guilty unknowlify and intellegently To 20 years! Here's my requestings of These documents so I'll Have Showing why I requested at the County Jail for an examine Too. ⟶

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you see Basically if I would of Been eluated Before I'd Be sure To have Been classified mentally incompetent to not with stand alone In my case. and wouldn't of plead guilty Instead waited for proper asistance In a Fair Judgement. I would not plead To 20 years on my first offense ever as an adult! Im asking for a Time reduction Really simply a vacted sentence, Due To my County Failure and STATE unproper Judgements! Im showing forth How Mr. Grove was Ineffective By the records and all Thats In my case and records of errors. I Hope your Courts look into This with concerns and allow me Rendall Baccus a Chance at life again in a reasonable matter of Time.

Thank you,

11/24/16

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MAR 24/2009/TUE 08:46 AM SCDMH/MV ADMIN FAX No. 803 935 5726 NOV 30 2016

S.C. SUPREME COURT

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendall Baccus, at Ker-CI 4848 Goldmine Hwy Kershaw SC. 29067
(Name of requestor) Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-91-0123, Medical Record# 355137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ______

I authorize the release of the following information for the time period from Dec/2016 to JAN-2017.

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): McLeod Hospital Florence SC. 29501

AND The information authorized to be released includes:

☑ All information from above
☑ Diagnoses
☑ Clinical History & Evaluation
☑ Admission and Discharge Dates
☑ Individualized Treatment Plan Progress Summaries
☑ Discharge Summary (Summary of Treatment)
☑ Physician's Medication Orders
☑ History and Physical
☑ Psychiatric History and Mental Status Examination
☑ Consultant Notes
☑ Billing and Payment Information
☑ Written summary (copy attached)
☐ Other: ______

This information should be released to: (Kendall Baccus)

Name: Mental Health Ker-CI

Address: 4848 Goldmine Hwy
Kershaw SC. 29067

Telephone No: ______

Relationship: ______

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:

Before JAN-2017

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.

Kendall Baccus (signature) | Kendall Baccus | 11-22-16
Signature of Individual/Personal Representative | Printed Name | Date

Authority if signed by Personal Representative ______

______
Signature of DMH Staff releasing information | Printed Name | Method of Release | Date Released

SCDMH FORM
DEC. 99 (REV.APR 04) M-450D
MH-FCC-2

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendall Baccus (Name of requestor), at KER-CI/ 4848 Goldmine Hwy Kershaw SC. 29067 Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-91-0173, Medical Record# 355137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ______

I authorize the release of the following information for the time period from Dec-2016 to JAN-2017

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): Mental Health office of Lake city SC. 29530

AND The information authorized to be released includes:

- ☑ All information from above
- ☑ Diagnoses
- ☑ Clinical History & Evaluation
- ☑ Admission and Discharge Dates
- ☑ Individualized Treatment Plan Progress Summaries
- ☑ Discharge Summary (Summary of Treatment)
- ☑ Physician's Medication Orders
- ☑ History and Physical
- ☑ Psychiatric History and Mental Status Examination
- ☑ Consultant Notes
- ☑ Billing and Payment Information
- ☐ Written summary (copy attached)
- ☐ Other: ______

This information should be released to: (Kendall Baccus)

Name: Mental Health KER-CI

Address: 4848 Goldmine HWY Kershaw SC. 29067

Telephone No: ______

Relationship: ______

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:

Before JAN - 2017

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] Signature of Individual/Personal Representative — Kendall Baccus, Printed Name — 11-22-16, Date

Authority if signed by Personal Representative ______

Signature of DMH Staff releasing information | Printed Name | Method of Release | Date Released

MAR 24/2009/TUE 03:46 AM SCDMH/MV ADMIN FAX No. 803 935 5736

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendull Baccus (Name of requestor), at Ker-CI 4848 Goldmine Hwy Kershaw SC. 29067 Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-91-0173, Medical Record# 355137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ______

I authorize the release of the following information for the time period from Dec-2016 to JAN 2017

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): Mental Health office of Bishopville, SC 29010

AND The information authorized to be released includes:

- ☑ All information from above
- ☑ Diagnoses
- ☑ Clinical History & Evaluation
- ☑ Admission and Discharge Dates
- ☑ Individualized Treatment Plan Progress Summaries
- ☑ Discharge Summary (Summary of Treatment)
- ☑ Physician's Medication Orders
- ☑ History and Physical
- ☑ Psychiatric History and Mental Status Examination
- ☑ Consultant Notes
- ☑ Billing and Payment Information
- ☑ Written summary (copy attached)
- ☐ Other: ______

This information should be released to: (Kendall BACCUS)

Name: Mental Health Ker/CI

Address: 4848 Goldmine Hwy Kershaw SC. 29067

Telephone No: ______

Relationship: ______

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:

Before JAN-2017

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] Kendall Baccus 11-22-16

Signature of Individual/Personal Representative | Printed Name | Date

Authority if signed by Personal Representative ______

______

Signature of DMH Staff releasing information | Printed Name | Method of Release | Date Released

SCDMH FORM
DEC. 99 (REV.APR 04) M-450D
MH-FCC-2

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendall M Baccus, at Ker-CI 4848 Goldmine Hwy Kershaw SC. 29067
(Name of requestor) Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-41-0173, Medical Record# 355137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ____

I authorize the release of the following information for the time period from Dec-2016 to JAN-2017.

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): Pee Dee Mental Health Florence SC

AND The information authorized to be released includes:

- ☑ All information from above
- ☑ Diagnoses
- ☑ Clinical History & Evaluation
- ☑ Admission and Discharge Dates
- ☑ Individualized Treatment Plan Progress Summaries
- ☑ Discharge Summary (Summary of Treatment)
- ☑ Physician's Medication Orders
- ☑ History and Physical
- ☑ Psychiatric History and Mental Status Examination
- ☐ Consultant Notes
- ☐ Billing and Payment Information
- ☐ Written summary (copy attached)
- ☐ Other: ____

This information should be released to: (Kendall Baccus)

Name: Mental Health Ker/CI

Address: 4848 goldmine Hwy Kershaw SC 29067

Telephone No: ____

Relationship: ____

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:

Before JAN-2017 actually

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.

Kendall Baccus [signature]	Kendall Baccus	11-22-16
Signature of Individual/Personal Representative	Printed Name	Date

Authority if signed by Personal Representative ____

Signature of DMH Staff releasing information	Printed Name	Method of Release	Date Released

SCDMH FORM
DEC. 99 (REV.APR 04) M-450D
MH-FCC-2

MAR 24/2009/TUE 08:46 AM SCDMH/MV ADMIN FAX No. 803 935 5726

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendall Baccus (Name of requestor), at Ker-CI 4848 Goldmine HWY Kershaw SC. 29067 Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-91-0173, Medical Record# 355137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ______

I authorize the release of the following information for the time period from Dec-2016 to JAN-2017

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): Dept. of Mental Health, 2200 Harden St. Columbia SC

AND

The information authorized to be released includes:

- ☑ All information from above
- ☑ Diagnoses
- ☑ Clinical History & Evaluation
- ☑ Admission and Discharge Dates
- ☑ Individualized Treatment Plan Progress Summaries
- ☑ Discharge Summary (Summary of Treatment)
- ☑ Physician's Medication Orders
- ☑ History and Physical
- ☑ Psychiatric History and Mental Status Examination
- ☑ Consultant Notes
- ☑ Billing and Payment Information
- ☑ Written summary (copy attached)
- ☐ Other: ______

This information should be released to: (Kendall Baccus)

Name: Mental Health Ker/CI

Address: 4848 Goldmine Hwy Kershaw SC 29067

Telephone No: ______

Relationship: ______

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:

Before JAN-2017

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.

Kendall Baccus (signature) — Signature of Individual/Personal Representative

Kendall Baccus — Printed Name

11-22-16 — Date

Authority if signed by Personal Representative ______

Signature of DMH Staff releasing information | Printed Name | Method of Release | Date Released

SCDMH FORM
DEC. 99 (REV.APR 04) M-450D
MH-FCC-2

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, Kendall M. Baccus, at Ker-CI 4848 Goldmine Hwy. Kershaw SC, 29067
(Name of requestor) Address (Street, City, State, ZIP)

DOB 11-25-92, SS# 248-91-0173, Medical Record# 335137 authorize the release of my SCDMH health information, as specified below, for the following purpose: ____________

I authorize the release of the following information for the time period from Dec. 2016 to JAN - 2017.

☑ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☑ Information from (name of specific hospital): Williams. Hall Columbia, SC

AND The information authorized to be released includes:

- ☑ All information from above
- ☑ Diagnoses
- ☑ Clinical History & Evaluation
- ☑ Admission and Discharge Dates
- ☑ Individualized Treatment Plan Progress Summaries
- ☑ Discharge Summary (Summary of Treatment)
- ☑ Physician's Medication Orders
- ☑ History and Physical
- ☑ Psychiatric History and Mental Status Examination
- ☑ Consultant Notes
- ☑ Billing and Payment Information
- ☑ Written summary (copy attached)
- ☐ Other: ____________

This information should be released to: (Kendall Baccus)

Name: Mental Health KerCI

Address: 4848 Goldmine Hwy, Kershaw SC, 29067.

Telephone No: ____________

Relationship: ____________

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'd prefer recieving before JAN. 2017.

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]	Kendall Baccus	11-22-16
Signature of Individual/Personal Representative	Printed Name	Date

Authority if signed by Personal Representative ____________

Signature of DMH Staff releasing information	Printed Name	Method of Release	Date Released

SCDMH FORM
DEC. 99 (REV. APR 04) M-450D
MH-FCC-2

Kendall Baccus II 355137
Ker- CI - RHU - 94 th CYP
1848 Goldmine Hwy
Kershaw SC, 29067

Daniel E. Shearouse
Clerk of Court
The Supreme Court of South Carolina
Post office Box 11330
Columbia, South Carolina 29211

Baccus 355137
LEGAL

NOV 28 2018

KerCI
MAILROOM

SC DEPARTMENT OF CORRECTIONS
KERSHAW CORRECTIONAL INSTITUTION