# CAROLINA MEDICAL CONSULTANTS
# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: ________________________________________Date:_______________

Address: ________________________________________________________________

Date of Birth: ______/______/______ SS #: _______________________

I hereby authorize the release of my medical records from:

________________________________________

________________________________________

________________________________________

Information released to: ___New Primary Care Physician

Carolina Medical Consultants, P.A.
311 Glenwood Drive
Rock Hill, South Carolina 29732
803-366-7175 FAX 803-366-0529

Information to include:
__Office Visits
__Laboratory Results
__Pathology Reports
__Radiology Reports
__ECG/EEG
__Entire Record

Purpose of Disclosure:
__Continuing Treatment
__Staff/Physician Issue
__Change in Insurance
__Personal
__Other_______________

NOTICE: This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of visits, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.

Exclusions: ______________________________________________________________

RESTRICTIONS: I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not have any effect on information released prior to notification of cancellation.
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.

Signature of Patient/Legal Authority: ____________________________________________
Date: _____________