

Carolina Medical Consultants
311 Glenwood Drive
Rock Hill, S.C. 29732
(803) 366-7175

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print **patients** full name) Birth date (Mo/Day/Yr) _____

(Street address) Phone (Home) _____

(City, state, zip code)

At the request of the individual, I _____, do hereby authorize the release of:

(Patients name)

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER _____
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH	_____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST	_____ INSURANCE	_____ WORKERS COMP	_____ CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	_____ PERSONAL	_____ OTHER _____

Please provide a current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's estate**

Date

NOTE: HealthPort has been contracted to provide the service of processing medical records request. Currently, the charge is \$0.65 (1-30 pgs) \$0.50 (31+) plus actual postage for a personal copy or the permanent transfer of your records. HealthPort will invoice you directly.

MEDICAL INFORMATION RELEASED BY SMART DOCUMENT SOLUTIONS

Entire _____	X-Ray / MRI _____	Pathology _____	_____
HP _____	EKG / Echo _____	_____	ROI SPECIALIST _____
Lab _____	Immunizations _____	OTHER _____	DATE _____