

CAROLINA MEDICAL CONSULTANTS, PA  
AUTHORIZATION TO RELEASE PROTECTED  
HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

I hereby authorize the release of my PHI from Carolina Medical Consultants to:  
(list full name of person and relationship and type of information to release)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my PHI. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_