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Charleston, SC 29414
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Mount Pleasant, SC 29464
P: (843) 971-2992 F: (843) 971-2998

776 Daniel Ellis Drive, Building 2 Suite A
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P: (843) 795-8100 F: (843) 573-2534

9165 University Blvd. Ste. 100
Charleston, SC 29406
P: (843) 284-4255 F: (843) 284-425

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Patient Address: _____ City: _____

State: _____ Zip Code: _____ Patient Phone Number: (____) _____ - _____

The undersigned hereby authorizes, _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

to release the following portions of the medical records of the above named patient.

() Entire Medical Record for the period of _____ to _____

() The following specific portions of the medical record: _____

for the period of _____ to _____

Release this information to:

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____ Email: _____

I understand that I may REVOKE this release at any time, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that, unless I specify otherwise, this release form may authorize release of information related to physical illness, mental illness, and communicable diseases, including but not limited to HIV, AIDS, and/or AIDS related information. I also understand that faxed or photo copies of the release are permissible and if I am requesting copies for self-records there will be a fee as defined in SC State Law Section 44-7-130.

Signature of Patient or Legal Representative if patient is a minor

_____ Date: ____/____/____

Relationship if other than patient: _____