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 #: (_____) _____-_____ Fax #: (_____) _____-_____

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:

Entity: _____
Address: _____ City: _____
State: _____ Zip Code: _____hone #: (_____) _____-_____ Fax #: (_____) _____-_____

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 photocopies 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: _____