Carolina Medical Consultants, PA

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Authorization to Release Protected Health Information (PHI)

Date: _____

Patient Name: _____ DOB: _____

To authorize Carolina Medical Consultants, PA to release your medical records to you or someone other than yourself, such as another physician, a family member or friend, or insurance company, I will need to provide a written list of those persons below. 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. I also understand that I can revoke or add to any of the names on this list at any time as long as it is in writing.

I hereby authorize the release of my PHI from Carolina Medical Consultants, PA to the following persons, physicians, and/or organizations:

Name:	Phone Number: **REQUIRED**	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other physicians, laboratories, insurance companies, or other entities, in regards to my medical care and collection of payment for services rendered. I consent to such disclosure for these permitted uses, including disclosures via fax.

Signature: _____ Date: _____