

Carolina Medical Consultants, P.A.

Authorization for Release of Medical Information

(Print **patient's** full name)

Birth Date (MM/DD/YY)

Street Address

Social Security Number

City, State, Zip Code

Primary Contact Number

At the request of the individual, I _____, do hereby authorize **Carolina Medical Consultants** to release:
(patient's name)

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	_____
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> ECG/EEG/CARDIAC 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.

RELEASE INFORMATION TO:

Name of Company/Agency/Facility/Person

Street Address

City, State, Zip

PURPOSE OF DISCLOSURE:

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP	<input type="checkbox"/> CHANGE OF DOCTOR
<input type="checkbox"/> LEGAL INVESTIGATION	<input type="checkbox"/> DISABILITY DETERMINATION	<input type="checkbox"/> PERSONAL	
OTHER (SPECIFY) _____			

Please provide 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 or 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: THERE WILL BE A CHARGE OF \$0.65 PER PAGE FOR 1-30 PAGES, \$0.50 PER PAGE 31+ PAGES PLUS ACTUAL POSTAGE FOR A PERSONAL COPY OR THE PERMANENT TRANSFER OF YOUR RECORDS. HEALTHPORT CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. THERE MAY BE A DELAY OF RECORDS BEING SENT DUE TO NON-PAYMENT.

MEDICAL INFORMATION RELEASED BY HEALTHPORT CORPORATION

ENTIRE _____	LAB _____	EKG _____	_____
DS _____	EKG _____	IMMUNE _____	ROI SPECIALIST
OP _____	X-RAY _____	OTHER _____	_____
HP _____	PATH _____	_____	DATE