Carolina Medical Consultants, P.A.
Authorization for Release of Medical Information

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_____ _____
(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)

_____ DISCHARGE SUMMARY _____ PATHOLOGY REPORTS _____ EMERGENY REPORTS
_____ HISTORY & PHYSICAL _____ LABORATORY REPORTS _____ OTHER _____
_____ PROGRESS NOTES _____ RADIOLOGY REPORTS _____
_____ OPERATIVE NOTES _____ 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:
_____ REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ 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