Carolina Medical Consultants, P.A.
Authorization to Release Medical Records

Matthew D. Jenkins, M.D., John Hoitink, M.D, Rhea Hsu, M.D., Randolph Villamor, M.D.,
Sheryl Lamb, APRN., Denine Raymond, APRN

Patient Name: _____ Date of Birth: _____/_____/_____
Month / Day / Year

Address: _____

Patient Phone #: _____ Social Security Last 4 #s _____

I hereby Authorize the release of my medical records from:

Clinic or Physician: _____ Phone: _____

Address:_____ Fax: _____

Send information to:

Carolina Medical Consultants, P.A.
311 Glenwood Drive
Rock Hill, SC 29732-1818
Phone: (803)366-7175 Fax: (803)366-2099

Purpose of Disclosure:
☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Personal
☐ Other _____

Records from ____ to ____.
☐ Laboratory Results
☐ Pathology Reports
☐ Radiology Reports
☐ Office Visits
☐ Most Recent Colonoscopy/ EGD
☐ Most Recent Pap
☐ Most Recent Mammogram
☐ Entire record(LAST 2 YEARS ONLY)
☐ Other Specify _____

****PLEASE ONLY SEND REQUESTED INFORMATION****
****DO NOT FAX OVER 20 PAGES** **PLEASE MAIL ANYTHING OVER 20 PAGES****

NOTICE: This authorization is for Full Disclosure of the Requested Records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of healthcare personnel, dates of visits and any information that may be related to drug, alcohol, psychiatric conditions and/or specific information. Exclusions to this request are: _____

RESTRICTIONS: I understand the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand I may cancel this request with written authorization but I will not have any effect on information released to notification of cancellation.
This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclose without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.

_____ Date: _____
Signature of Patient or Legal Guardian

If legal Guardian state relationship to Patient: _____ Paperwork on file for guardian designation ☐
To be marked by CMC office staff only