Medical Records Request Authorization

I, _____, hereby authorize

_____

_____

_____

to disclose the following protected health information (Describe the information to be disclosed, including, but not limited to, date of service, type of service provided, level of detail to be released, origin of information, etc.):

_____

_____

To: Carolina Retina Center, P.A.
7620 Trenholm Road Ext.
Columbia, SC 29223

Phone: 803-736-7200
Fax: 803-736-2116

This protected health information is being used or disclosed for the purpose of:
(Describe specific purpose of disclosure)

_____

_____

This authorization shall be in force and effect until _____
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the medical office named above disclosing information. I understand that a revocation is not effective to the extent that the medical office has relied on the use of disclosure of protected health information.

I understand that the named medical office may not condition my treatment and/or payment on whether I provide authorization.

I also understand that I have the right to refuse to sign this authorization.

Please sign below to indicate that you have read this Authorization and agree with its terms:

_____ _____
Signature of Patient or Personal Representative | Name of Patient or Personal Representative (print)

_____ _____
Date | Relationship to patient (or other authority to serve)

_____ _____
Patient's Date of Birth | Patient's Social Security Number