METROLINA MEDICAL ASSOCIATES
2670 Mills Park Dr
Rock Hill, SC 29732
803-985-3939

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____

(Print patient's full name) Birth date (Mo/Day/Year)

_____ _____

Last five digits of SSN Telephone#

I do hereby authorize _____ to release the following medical records:

____ Discharge Summary ___ Pathology Reports ___ Emergency Reports
____ History & Physical ___ Laboratory Reports ___ Progress Notes
____ Radiology Reports ___ Operative Notes ___ ECG/EEG/Cardiac
____ Other: _____

___ 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.

Information Release to: Metrolina Medical Associates
2670 Mills Park Drive
Rock Hill, SC 29732
Telephone: 803-985-3939 Fax:803-985-3929

Purpose of Disclosure:

____ Primary Care Physician ____ Insurance ____ Legal ____ Personal
____ Disability Determination ____ Referral to Specialist
____ Other: _____

I hereby authorize disclosure of 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 affect 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 of 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, 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