Palmetto Internal Medicine
& Primary Care, P.A.

P:864-277-8300
F:864-288-8722

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____ _____ _____

Patients Name | Date of Birth | Social Security Number

I authorize:

Name of Previous Physician: _____

Address: _____

Phone #: _____ Fax #: _____

To release my records to:

Palmetto Internal Medicine & Primary Care, P.A.
300 West Butler Road
Mauldin, SC 29662

The following information is to be released:

_____ Only Last Three Office Notes/most recent lab work

_____ All medical records including any records protected under State and Federal Confidentiality Statuses: Drug/Alcohol Treatment, HIV-related information, Psychiatric Treatment, Transfer Care and Patient Care.

_____ Only specific portions of the medical record. Itemize portions of record to be released and indicate specific records that may not be released.

This authorization is valid for 90 days from the date of signature. I understand that revocation may not be made if the action has already been taken in reliance on this authorization.

_____ _____ _____

Patient's Signature | Date | Witness

If patient is unable to sign, complete the following: Patient is a minor, _____ years of age or patient is unable to sign because _____.