# AUTHORIZATION FOR RELEASE OF INFORMATION

CHART # ______________

PATIENT INFORMATION:

NAME OF PATIENT ______________________________ DATE OF BIRTH ______________

ADDRESS______________________________________________

CITY, STATE, ZIP ______________________________________________

NAME & ADDRESS OF COVERED ENTITY AUTHORIZED TO RELEASE INFORMATION:
CAROLINA HEALTH CARE, CAROLINA PODIATRY ASSOCIATES, MEDICAL MANAGEMENT INC., P.O. BOX 1905, FLORENCE, S.C. 29503 IS AUTHORIZED TO DISCLOSE PROTECTED HEALTH INFORMATION ON
______________________________ TO THE ENTITIES NAMED BELOW.
patient's name

ENTITY TO RECEIVE INFORMATION. INITIAL EACH THAT IS SUBJECT TO THIS AUTHORIZATION.

__________ YES / NO LEAVE INFORMATION ON MY VOICE MAIL/ANSWER MACHINE.
__________ YES / NO GIVE INFORMATION TO MY SPOUSE.
__________ YES / NO GIVE INFORMATION TO THE FOLLOWING PERSONS:

______________________________________________
______________________________________________

DESCRIPTION OF INFORMATION TO BE RELEASED.

__________ YES / NO DATE AND TIME OF MY NEXT APPOINTMENT AND WITH WHOM.______________
__________ YES / NO INFORMATION RESULTS FROM ANY TESTS OR X-RAYS.
__________ YES / NO FINANCIAL INFORMATION
__________ YES / NO MEDICAL /HEALTH INFORMATION
__________ OTHER INFORMATION AS DESCRIBED: ______________________________

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL REVOKED BY THE PATIENT OR REPRESENTATIVE SIGNING THE AUTHORIZATION.

THE PERMITTED USE OF THE INFORMATION IS TO INFORM THE PATIENT.

RIGHTS OF THE PATIENT:

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO CAROLINA HEALTH CARE. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO CAROLINA HEALTH CARE, P.O. BOX 1905, FLORENCE, S.C. 29503-1905.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

______________________________ DATE______________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

______________________________
PRINT OR TYPE NAME OF PATIENT OR PERSONAL REPRESENTATIVE

______________________________
PERSONAL REPRESENTATIVE'S AUTHORITY
(ATTACH NECESSARY DOCUMENTATION)

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