Medical Record Release Form

Carolina Medical PARTNERS
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Indian Land, SC 29707
Phone: 803.547.8660 **Fax:** 803.650.3880
info@carolinamedicalpartners.com

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Phone Type: ☐ Home ☐ Work ☐ Cell ☐ Other: _____

I hereby authorize the below listed entity to release medical information to Carolina Medical Partners:

_____ _____
Entity's Name Email Address

_____ _____
Phone Number Fax Number

_____
Address City State Zip

Medical Information Requested:

☐ All Records

☐ Specific Records from _____ to _____

☐ Immunizations & Physical Examinations

☐ Radiology Films (X-Ray, Labs, Mammography, Ultrasound, CT, MRI, etc.)

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Legal Guardian Full Name *(if applicable)* **Relationship to Patient**

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.