THE CAROLINA CENTER FOR
RHEUMATOLOGY & ARTHRITIS CARE, P.A.

Medical Release Form

Release of Information FROM our practice

I hereby authorize the use and/or disclosure of my identifiable health information to be released FROM, **The Carolina Center for Rheumatology and Arthritis Care, P.A., 744 Arden Lane, Suite 225, Rock Hill, SC 29732**, as described below:

Patient Name _____ DOB _____

Information to be released will include:

- o Complete Medical Record
- o Lab/Pathology Report
- o Office Notes from _____ to _____ DOS related to the diagnosis of _____

The purpose of this disclosure is for:

- o Coordination of Care
- o Personal Use
- o Medical Review
- o Legal Review
- o Insurance Review
- o Other _____

Information to be released to:

Name of Physician/Practice/Other: _____

Address: _____

Phone: _____ Fax: _____

- o I **DO** consent to having this information disclosed.
- o I **DO NOT** consent to having this information disclosed.

_____ _____

PATIENT SIGNATURE DATE

744 Arden Lane, Suite 225, Rock Hill, SC 29732-3288
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