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

Medical Release Form

Release of Information TO our practice

Information to be released FROM: _____ Fax#: _____
Phone#: _____

I hereby authorize the use and/or disclosure of my identifiable health information as described below. *Send only those records that are pertinent to my visit with The Carolina Center for Rheumatology and Arthritis Care, P.A*.

Patient Name: _____ DOB: _____

SS#: _____ Phone Number: _____

Information to be released will include:

- o **Medical Record – Last 4 office visits**
- o **Notes Office from _____ to _____ DOS related to diagnosis of _____**
- o **Lab/Pathology Reports**
- o **X-ray Reports**

The purpose of this disclosure is for:

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

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

_____ _____
Patient Signature **Date**

Please fax the above information to (803) 329-4118. If the file is over 30 pages please mail to the below address. Thank you.

744 Arden Lane, Suite 225, Rock Hill, SC 29732-3288
Phone: 803-329-1660 Fax: 803-329-4118

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