

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Full Name

Date of Birth

Social Security Number

Patient's Address

Patient's Home Phone Number

City, State Zip Code

Patient's Work Phone Number

RELEASE TO **RECEIVE FROM**

- Primary Care Associates, P.C.**
2000 E. Greenville Street, Ste 1600
Anderson, SC 29621
Ph: 864-226-9193 Fax: 864-231-0281

- Primary Care Associates, P.C.**
726 Anderson Street
Belton, SC 29627
Ph: 864-338-8619 Fax: 864-338-9707

RELEASE TO **RECEIVE FROM**

Name (Patient/Practice/Company)

Address

City, State Zip Phone Number

I request the following records to be released to Primary Care Associates, PC:

- _____ Last 3 Progress notes _____ Last Hospital Discharge & Summary Report
- _____ All MRI/CT/US Scans _____ Last EKG & All Cardiac Testing
- _____ All Immunizations _____ Last Mammogram _____ Last Colonoscopy _____ Last Eye Exam
- _____ All Pathology Reports (including PAP Smears) _____ Other-_____

- This authorization lasts for one year after the date you sign it.
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Your cancellation must be in writing to revoke this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Primary Care Associates, P.C. may include records that it received from other organizations. If these records have been used by Primary Care Associates, P.C. and filed in the record Primary Care maintains about you, these records may be released with your Primary Care records.
- Primary Care Associates cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Primary Care Associates, P.C. from any and all liability resulting from a re-disclosure by the recipient.
- Your signature provides PCA with full authorization to release and/or obtain your Medical Records.
****NOTICE**** As stated in our financial policy there will be a charge for a copy of your records. If you have any questions about incurring charges, please feel free to call our office and ask to speak with someone in medical records concerning this matter.
****THIS FORM MUST BE FILLED OUT COMPLETELY IN ORDER FOR RELEASE TO BE COMPLETED****

Signature _____

Date _____

Witness Signature _____

Date _____