## 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: 864-512-6731 Fax: 864-512-6734

☐ **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) _____ Labs _____ 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_____