Southeast Pulmonary & Critical Care
370 South Herlong Ave. Suite 200 Rock HIll, SC 29732 (803) 980-LUNG (5864)

Authorization for Release of Medical Records to Southeast Pulmonary & Critical Care

_____ _____
Print Patient's Full Name Date of Birth (Mo/Day/Year)

_____ _____
Telephone Number Last five digits of SSN

I do authorize _____ to release the following medical records:

_____Consult Notes _____Pathology Reports _____Emergency Reports
_____Progress Notes _____Laboratory Reports _____Discharge Summary
_____History & Physical _____Radiology Reports _____Operative Notes
_____Other:_____

Release Information to: Southeast Pulmonary & Critical Care, LLC
370 S. Herlong Ave., Suite 200
Rock Hill, SC 29732
P-803-980-5864 F-803-980-5817

Purpose of Disclosure:

_____ Specialist Referral _____Insurance _____Legal _____Personal
_____ Primary Care Physician _____Disability Other:_____

I hereby authorize disclosure of protected health information for the above named patient. This authorization is valid for 2 years from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus, and alcohol and drug abuse. I authorize the release or disclosure of this type of information. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and then would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized, may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual or guardian or Personal Representative of patient's estate Date