# ***Family Medicine Centers of South Carolina***

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

| | |
|---|---|
| _____ | _____ |
| (Print **patients** full name) | Birth date (Mo/Day/Year) |
| _____ | _____ |
| (Street address) | Social Security Number |
| _____ | _____ |
| (City, state, zip code) | Phone (Home/Mobile) |
| _____ | _____ |
| Email Address | Account # (if known) |

At the request of the individual, I _____, do hereby authorize the release of: (Patient's Name)

_____ All medical records

_____ Other (Describe specific records to be released_____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Your current provider with Family Medicine Centers of South Carolina may be relocating within the Columbia area. For additional, updated information visit: www.fmcofsc.com

**INFORMATION RELEASE TO:** _____
Name of Company/Agency/Facility/Person

_____
Street address **OR** email address for secure email

_____
City, state, zip

**PURPOSE OF DISCLOSURE:**

_____CHANGE OF DOCTOR OTHER_____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months 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 used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished 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**

*See other side