Adult Medicine Specialists, PA

764 Saco Lowell Road, Easley, SC 29640
Phone: 864-855-5525 Fax: 864-855-5440

Authorization for Use and Disclosure of Protected Medical Information
PLEASE PRINT!!!

Patient's Full Name:_____ Date of Birth:_____
Street Address:_____ Social Security #:_____
City, State, Zip:_____ Phone Number:_____

AT THE REQUEST OF THE INDIVIDUAL, I _____ DO AUTHORIZE
Patient or Personal Representative

_____ TO
Name and Address of Medical Facility or Practice

RELEASE ALL RECORDS TO: **ADULT MEDICINE SPECIALISTS OF EASLEY**
764 SACO LOWELL ROAD EASLEY, SC 29640

AT THE REQUEST OF THE INDIVIDUAL, I _____ DO AUTHORIZE
Patient or Personal Representative
ADULT MEDICINE SPECIALISTS OF EASLEY TO RELEASE MY MEDICAL RECORDS TO:

_____
Name and Address of Medical Facility or Practice

I hereby authorize Adult Medicine Specialists of Easley, P.A. to use or disclose my personal health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

***I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable disease including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.
***Adult Medicine Specialists of Easley, P.A. may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.
***This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization or:
2. If the information was given the release records to your insurance company in order to obtain Insurance coverage.

***This authorization will automatically expire in 90 days unless otherwise stated.
***Expiration date:_____

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship of Legal Guardian

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Office use only:

Physician's Initials_____ Number of Pages Released_____ Date Released_____ Staff Initials_____