CAROLINA PAIN PHYSICIANS
9565 Highway 78 Suite 400
Ladson, SC 29456
Phone: (843) 737-0437 Fax: (843) 789-3053
info@carolinapainphysicians.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Patient's Home Phone: _____ Patient's Work/Cell Phone: _____

Patient's Address: _____

I request and authorize Dr. _____ Phone number: _____

Address: _____ Fax number: _____

To release healthcare information of the patient named above to:

Name: Carolina Pain Physicians

Address: 9565 Highway 78 Suite 400
Ladson, SC 29456

PLEASE FAX RECORDS TO (843) 789-3053

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: _____

☐ Yes ☐ No I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

X_____ _____

Signature of Patient / Parent or Authorized Representative Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.