CAROLINA PAIN PHYSICIANS
2811 Tricom Street North Charleston, SC 29406
Office: (843) 737-0437 Fax: (843) 789-3053

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 & authorize _____ Phone number: _____

Address: _____ Fax number: _____

To release my healthcare information to:

Carolina Pain Physicians
2811 Tricom Street
North Charleston, SC 29406

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.