Palmetto Medical Group

1040 Edgewater Corp Pkwy suite 101
Indian Land SC 29707
ph: 803-548-7007 f: 803-802-2015
Amit Shah, MD|Alexa-Gail Woolery, DNP, FNP-BC

Authorization To Disclose Health Information & Release Record

| Regarding Patient: | | | |
|---|------------------------------|---------------------------------------|-----------------------|
| | | | |
| Last Name | First Name | | M |
| | | | |
| Address | | City State | Zip code |
| Phone: | | Birthdate: | |
| | | | |
| Information Released From: | | | |
| | | | |
| | | | |
| Name (Health Care Prov | ider) | Phone Number | Fax Number |
| | | | |
| Address | City | State | Zip Code |
| Information Released To: | | | |
| | | | |
| | | | |
| Name (Health Care Provide | er) | Phone Number | Fax Number |
| | / | | |
| Address | City | Phone Number | Fax Number |
| | | | |
| This Information Shall Include the Follo | wing: | | |
| Date(s) of service to release: | | | |
| | | | |
| ☐ Discharge Summary ☐ Operative Report | | Diabetic eye exam (most recent/within | n last 2 years) |
| ☐ History & Physical ☐ Pathology Report ☐ Laboratory Report ☐ Nursing Notes ☐ M | | | Progress/Office Notes |
| — — — — | most recent/within last 10 y | | CG/EEG/Cardiac Catri |
| Other | | | |
| (Specify): | | | |

NOTICE: This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, name of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information

will be disclosed unless specified information to exclude is listed below. **Exclusions: Purpose for Disclosure:** ☐ Continuing Treatment Insurance ■ Worker's Compensation Legal Investigation ☐ Disability Determination Personal Other (Specify): RESTRICTIONS: I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby authorize disclosure of the health information to the above-named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification, but that it will not have any effect on information released prior to notification of cancellation. Signature of Patient/Legal Authority: Date: ☐ Guardian Parent of Minor Legal Authority is: Attorney in Fact Next of Kin Executor of Estate Other Patient is: Minor Incompetent Disabled Deceased Documentation of legal status must be attached.

that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records