



430 S. Herlong Ave., Suite 104, Rock Hill, SC 29732
Phone 803.324.4900 · Fax 833-559-1046

Authorization to Release Medical Records

Complete one form for each provider. Return it to our office, or send it directly to the other provider's records department.

Patient

Patient name

Date of birth

Phone

Street address

City

State

ZIP

Direction of release

☐ Release records TO Palmetto Cardiology of York County

☐ Release records FROM Palmetto Cardiology of York County

Name of the other provider or facility

Street address

City

State

ZIP

Phone

Fax

Records requested

☐ Office notes and consultations

☐ Laboratory results

☐ EKG tracings

☐ Echocardiogram reports

☐ Stress test reports

☐ Cardiac catheterization reports

☐ Hospital discharge summaries

☐ Complete record

Date range of records requested

Other — please describe

Sensitive information

These categories have extra legal protection and are released only if you specifically initial them.

☐ Mental health records — initial: _____

☐ Substance use treatment — initial: _____

☐ HIV / AIDS related information — initial: _____

☐ Genetic testing — initial: _____

Authorization

I authorize the release of the records described above. I understand that I may revoke this authorization in writing at any time, except where information has already been released in reliance on it, and that this authorization expires one year from the date signed unless I specify otherwise below.

I understand that information released may be re-disclosed by the recipient and may then no longer be protected by federal privacy law. I understand that a fee may apply to copies of records.

This authorization expires on

Patient signature

Date

Printed name

If signing for the patient,
relationship