RECORDS RELEASE AUTHORIZATION

TO: _____

	EQUEST YOU TO RELEASE TO: GICAL ASSOCIATES, PA
	andell, M.D.
	. Colston, PA conam, M.D.
	9732 • Phone (803) 366-6135 Fax (803) 366-3439 9732 • Phone (803) 366-6135 Fax (803)329-8645
Description of information to be released /used: Date of Service: Service Provided:	Describe in detail the level of information to be released
Permitted use of the described information or reason for the request	 '
This authorization shall be in force and effect until: Date of Expiration (or) description of an event that will caus intended use or disclosure	
NAME	
ADDRESS	
	-
SSN: DATE OF BIRTH	
SIGNATUREDATE	
Rights of the Patient I understand that I have the right to revoke this authorization at any time be understand that information used or disclosed as a result of this authorization protected by federal or state law. Any information received by this office for understand that I have the right to inspect or copy the protected health in this by written notification to the address on this authorization.	ation may be subject to redisclosure by the recipient and may not longer be or our own use will continue to be protected by the Federal Privacy Rule.
I understand that my treatment will not be conditioned on signing this auth	orization.
I understand that I have the right to refuse to sign this authorization.	
Tandorstalla Blattinato the right to reliable to bight line scattering	
Signature of Patient Date	•
Print or Type Name of Patient or Personal Representative	
Description of Personal Representative's Authority (attach necessary doct	umentation)

Authorization for Release of Protected Health Information Metrolina Neurological Associates

7	Patient's Full Name			Patient's Date of Birth				
	Address			***************************************	Patient's Social	Security Number (last 4	digits) Option	
	City, State, Zip Cod	le		,,,,,	Patient's Telep	hone Number	(31)15121151515151515151515151515151515151	
	I hereb	y authori	ize use or disclosu	re of protected		about me as described be		
	Facility Name			 	_ is authorized to use	or disclose information :	about me to:	
Coi	mplete name & address		Recipient Nam	e:		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	**************************************	
	vhere records are to	→	Street Address				to the state of th	
be !	sent		City, State, Zip			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	······································	
			Phone/Fax Nur				The state of the s	
	Information for tre	atment p			To (date	e)		
	Information to be r	eleased: [☐ All Records OF	R (Please check	all that apply)			
	Office Notes/Ph	ysician L	Dictation	Pathology		Immunization Re		
	Laboratory Tes				diovascular	Physical Therapy	y Records	
	Radiology Repo	rts			id Reports	Other		
	martine	Bill Medication						
	Transfer (The	re will be	a charge billed to	Insurance the patient fo	Disability Dete	rmination Other lical records)		
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Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)