Clemson Eye

Medical Records Release

Authorization for Use

Patient Name: _____ Date: _____

SSN: _____ DOB: _____

Release records from: _____

Email: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) to disclose/release all medical records to: _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records to: Clemson Eye Clinic (circled) at the **fax** number below:

Anderson	Clemson	Clinton	Easley	Greenville – Halton Green Way	Greenville-Pelham	Newberry	Simpsonville	Saluda
864-622-5020	864-654-3275	864-833-0520	864-855-6850	864-987-0036	864-292-2020	803-276-4536	864-963-3232	864-445-9696

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Name: _____ Signature: _____ Date: _____

Patient / Guardian / Guarantor

Name: _____ Signature: _____ Date: _____

Witness