Clemson Eye

Medical Records Release Form

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(Gville St) (864) 622-5020	Anderson (Fant St) (864) 225-1139	Clemson (864) 654-3275	Clinton/Laurens (864) 833-0520	Easley (864) 855-6850
Greenville (Halton) (864) 987-0036	Greenville (Pelham) (864) 292-2020	Greenville (Lasik) (864) 297-8777	Newberry (803) 276-4536	Powdersville (864) 295-3242
Seneca (864) 973-6395	Simpsonville (864) 963-3232	Williamston (864) 847-6060		

Disclosure of Protected Health Information

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