CHARLESTON PULMONARY ASSOCIATES, P.A.
CAROLINA SLEEP SPECIALISTS, P.A.

125 Doughty Street Suite 200 Charleston, SC 29403 Phone 843.577.6791 Fax 843.577.0553
897 Von Kolnitz Road, Suite 104 Mt. Pleasant, SC 29464

Graham C. Scott, M.D., DABSM, FACP, FCCP
James J. Carswell IV, M.D., DABSM, FCCP
Steve E. Herndon, M.D.
Mary Anne Gould, FNP-BC

John A. Mitchell, M.D., DABSM, FCCP
Jason E. Gunn, M.D., FCCP
M. Atif Rashad, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: _____ Date of birth: _____

Previous name: _____

Circle your provider above (within letter head if you are requesting a record from Charleston Pulmonary (CPA).
If requesting records be sent to CPA, Please provide the providers name:_____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ❑ All my health information maintained by _____
  Include: ❑ Alcohol/Drug Treatment Records ❑ HIV/AIDS Records ❑ Mental Health Records
- ❑ My health information relating to the following treatment or condition: _____
- ❑ My health information for the date(s): _____
- ❑ Other: _____

You may disclose this health information to:
Charleston Pulmonary Associates, PA, Fax 843.577.0553 _____(inital)

Provider, Office Location, Fax & Phone _____

Reason(s) for this authorization (check all that apply):

- ❑ at my request
- ❑ other (specify) _____
- ❑ request electronic copy

This authorization ends:

- ❑ at six months from the date of this document, or on the following date _____
- ❑ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office; or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)