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

125 Doughty Street, Suite 200 Charleston, SC 29403
1300 Hospital Drive Suite 320 Mt Pleasant, SC 29464
2061 US-52 Moncks Corner, SC 29461
PHONE 843.577.6791 FAX 843.577.0553

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.)