

Family Medicine of SayeBrook, LLC

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AUTHORIZATION TO RELEASE INFORMATION

I, _____, _____
(name) (date of birth)
_____ hereby authorize release of my medical
(social security number)
records from:

Physician or Medical Facility _____

Address _____

Phone _____ Fax _____ to the attention of

___ Edward R. McCarthy, DO ___ Jonathan D. Bornfreund, DO ___ Karen L. Mahood, DO

Description of the information to be released: (check all that apply)

- ___ Labs
- ___ Discharge Summary
- ___ Medical Record 1 year
- ___ Other: _____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations.
- I understand that I may revoke or terminate this authorization by submitting a written revocation to Family Medicine of SayeBrook, LLC.

Patient (or patient representative) Signature: _____ Date: _____

Relationship of patient representative to patient: _____

Witness Signature: _____