Karen L. Mahood, DO
Edward R. McCarthy, DO
Jonathan D. Bornfreund, DO
Mercedes Davis, PA-C
Catherine Tumbleson, PA-C

106 Lansford Court, Ste. 100
Myrtle Beach, SC 29588
www.familymedicineofsayebrook.com

Phone 843-293-8850
Fax 843-293-8860

ACCT#: _____

AUTHORIZATION TO RELEASE INFORMATION FROM FAMILY MEDICINE OF SAYEBROOK, LLC

I,_____,_____
(name) (date of birth)

_____ hereby authorize release of my medical
(social security number)

records from Family Medicine of SayeBrook, LLC to:

Physician or Medical Facility _____
Address _____
Phone_____Fax _____

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

_____ Labs
_____ Medical Record 1 year
_____ Other: _____

- 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 the information in my medical records may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
- I understand that I may revoke or terminate this authorization by submitting a written revocation to Family Medicine of SayeBrook, LLC.
- I understand my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal regulations also prohibit any further re-disclosure of this information by the recipient with which you have consented. I hereby release FMS and any associated staff from all liability or legal responsibilities that may arise from the release of such records.

Patient (or patient representative)Signature:_____Date: _____
This authorization shall be in effect for one year from date signed.

Relationship of patient representative to patient: _____

Witness Signature: _____

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ACCT#: _____

AUTHORIZATION TO RELEASE INFORMATION

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

Physician or Medical Facility _____

Address _____
Phone_____Fax_____to the attention of:

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

__ Mercedes Davis, PA-C __ Catherine Tumbleson, PA-C

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

_____ Labs
_____ Discharge Summary
_____ Radiology (CT, MRI, X-Ray)
_____ Medical Records x **1 year**
_____ Immunization Record
_____ EKG
_____ Dexascan

Patient information is needed for:
_____ Continuing Medical Care
_____ Other: _____
_____ Personal Use

- I understand that the information in my medical records may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
- 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.
- I understand my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal regulations also prohibit any further re-disclosure of this information by the recipient with which you have consented. I hereby release FMS and any associated staff from all liability or legal responsibilities that may arise from the release of such records.

Patient (or patient representative)Signature:_____Date: _____
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Witness Signature**:** _____