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Authorization to Release Protected Health Information

Client Name: _____

Address: _____

Hereby request and authorize _____
PROVIDER NAME

To release medical records regarding: _____
CLIENT NAME

For the purpose of: _____

Approximate dates of service requested: _____

To: _____
PHYSICIAN/INDIVIDUAL RECEIVING RECORDS

PRACTICE NAME/GROUP NAME

ADDRESS, CITY, STATE, ZIP

If my initials appear here, _____, I specifically authorize release of drug and / or alcohol abuse treatment.

If my initials appear here, _____, I specifically authorize release of information concerning HIV testing and results.

If my initials appear here, _____, I specifically authorize release of information concerning psychiatric treatment. Special authorization for release of information about treatment of depression and anxiety is not required.

If my initials appear here, _____, I specifically authorize release of photographs taken for medical purposes.

I understand I may revoke this authorization at any time (except retroactively), and if not revoked earlier, this authorization will automatically expire in 180 days.

SIGNATURE OF CLIENT/LEGAL REPRESENTATIVE

SIGNATURE OF WITNESS

PRINT NAME OF CLIENT/LEGAL REPRESENTATIVE

PRINT NAME OF WITNESS

DATE

DATE