Carolina Musculoskeletal Institute, P.A.

Authorization for Release of Protected Health Information

Patient Name (at time of treatment) _____

Date of Birth _____ Social Security Number xxx – xx - _____

Address _____

Telephone # _____ CMI Account #: _____

Physician's Name or Office Name: _____
Address: _____
City/State/Zip Code: _____
Phone # : _____ Fax # : _____ Email: _____
(required for electronic delivery)

I authorize the provider name listed above to release my protected health information to:

Carolina Musculoskeletal Institute, P.A.
410 University Parkway
Suite 1400 Rheumatology
Suite 2600 Pain Management/Podiatry
Aiken SC 29801
Phone: 803-644-4264 Fax: Rheumatology 803-617-1984 /Pain Management 803-649-3333 Podiatry 803-649-0042

Information for treatment period: From (date): _____ to (date): _____

Information to be released (**please check all that apply**)

- Standard Record Set (office notes, labs, consults, op notes, imaging, PT)
- Office Notes
- Operative Reports
- Imaging Reports
- Other _____

This information is being requested for the following purpose(s):

_____

Sensitive Information: I understand that my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will bel released.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information then may not be protected by federal confidentiality rules.
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to the above medical provider and that revocation will not apply to information already released based on this information.
Expiration: I understand that this authorization will expire twelve (12) months after signed unless an earlier date is specified here: _____
Services: I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Description of Legal Representative's Authority

This facility has partnered with CIOX health to process and fulfill your request for a copy of your medical record.
Due to the strict procedural and highly regulated steps involved in this process, known as the release of information process, there are costs associated and, therefore, a fee is charged for this service. (Fee schedule available upon request).
Payment for records is not accepted on site; you will receive an invoice from CiOX Health via mail, which can be paid upon receipt.