



**Authorization to obtain Medical Records**

Patient Name (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 #: \_\_\_\_\_

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

Carolina Musculoskeletal Institute, P.A.  
410 University Parkway  
Suite 2600 Pain Management  
Suite 2600 Podiatry  
Aiken SC 29801  
Phone: 803-644-4264  
Fax: Pain Management - 803-649-3333  
Fax: 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 be 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 Authority

**CMI PAIN MANAGEMENT**  
Phillip T. Suwan, M.D.  
Fax (803) 649-3333

**CMI PODIATRY**  
Angela D. Molnar  
Fax (803) 649-0042

**410 University Parkway**  
Suite 2600  
Aiken, SC 29801  
Phone (803) 644-4264