Medical Provider's Name:
Carolina Musculoskeletal Institute, P.A.
410 University Parkway
Pain Management Suite 2600
Podiatry Suite 2600
Aiken SC 29801
Phone: 803-644-4264/ Fax Numbers: Pain Management 803-649-3333/ Podiatry 803-649-0042

Please Circle Method of Delivery: Electronic Delivery
Mail
Patient Pickup

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 #: _____

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

Recipient Name: _____ Attention to: _____

Street Address: _____

City/State/Zip Code: _____

Fax: _____ **Email: _____
(required for electronic delivery only)

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 Notes
□ 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 that 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 the 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
(Attach necessary documents)

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.

02/25/2022