1523 B Heritage Lane
Florence, SC 29505
843.673.0900

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Information

Patient Full Name: _____ *Date of Birth:* _____

Patient Address: _____ *Home Phone:* _____

City: _____*State:* _____ *Zip:* _____ *Work Phone:* _____

Release Information To

_____ I hereby Authorize USAAJJ Medical to release my medical record information to:
_____ I hereby Authorize the Physician or Facility listed below to release my medical information to USAAJJ Medical.

_____ Mail/fax copies to: ____ Hold for Patient Pick-up ____Discuss Medical Information with:

Name/Facility: _____ *Attention:* _____

Address: _____ *Phone:* _____

City: _____*State:* _____ *Zip:* _____ *Fax:* _____

Information to be Released

____ Progress Notes ____Laboratory Reports ____Pathology Reports

Duration
This authorization shall be effective immediately and remain in effect for 90 days from the signature date.

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature: _____ *Print Name:* _____

Relationship to patient (self, parent, spouse) _____ *Witness:* _____