MEDICAL INFORMATION RELEASE FORM

Name: _____ DOB: _____

I understand that Low Country Rheumatology maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is **NOT** to be released to anyone

☐ Check if okay to leave detailed health information on voicemail

Patient Signature _____ Date _____

Witness Signature _____ Date _____