CAROLINA EYECARE PHYSICIANS, LLC

# MEDICAL INFORMATION RELEASE FORM

**Patient Information:**

| | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Date of Birth: | |

**Request Medical Information FROM:** ☐ Carolina Eyecare Physicians ☐ Other (fill in information below)

| | | | |
|---|---|---|---|
| Physician/Practice Name: | | | |
| Address: | | | |
| City: | State: | Zip: | Phone: |

**Send Medical Information TO:**

☐ **Carolina Eyecare Physicians**

- ☐ **West Ashley:** 2060 Charlie Hall Blvd., Suite 201 - Charleston, SC 29414 – 843.722.2010 Fax 843.723.3914
- ☐ **West Ashley II:** 1637 Savannah Highway – Charleston, SC 29407 – 843.766.3768 Fax 843.769.4200
- ☐ **North Charleston:** 2861 Tricom Street – North Charleston, SC 29406 – 843.797.5511 Fax 843.797.0638
- ☐ **North Charleston II:** 9279 Medical Plaza Drive, Suite D – North Charleston, SC 29406 – 843.884.1011
- ☐ **Mt. Pleasant:** 1101 Johnnie Dodds Blvd – Mt. Pleasant, SC 29464 – 843.881.EYES Fax 843.375.1487
- ☐ **Mt Pleasant/Mathis Ferry:** 242 Mathis Ferry Road – Mt. Pleasant, SC 29464 – 843.884.1101 Fax 843.884.4773
- ☐ **Summerville:** 296 Midland Parkway – Summerville, SC 29485 – 843.873.5577 Fax 843.873.5583
- ☐ **Walterboro:** 459 Spruce Street – Walterboro, SC 29488 – 843.549.9500 Fax 843.549.6885
- ☐ **Moncks Corner:** 730 Stoney Landing Road – Moncks Corner, FL 29461 – 843.899.3393
- ☐ **Georgetown:** 1200 Highmarket Street – Georgetown, SC 29440 – 843.793.5437

☐ **Other:**

| | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip: |

☐ Complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to_____.

**Reason(s) for Records Request:**

- ☐ Moving out of the area
- ☐ Insurance Change. New Insurance: _____
- ☐ Change of provider. Provider Name: _____
- ☐ Primary physician needs records
- ☐ Copy for northern physician
- ☐ Other (please explain): _____

***I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.***

_____ _____ _____

**Patient or Legal Representative** **Date** **Witness** **Date**

Please allow 10 business days for processing your request.

| FOR OFFICE USE ONLY | | | | | |
|---|---|---|---|---|---|
| **Release Approval** | **Dr. Boatwright** | **Dr. Herring** | **Dr. Newland** | **Dr. Reuther** | **Dr. Solomon** |
| **Date:** | **Dr. Brame** | **Dr. Burger** | **Dr. Folgar** | **Dr. Knowlton** | **Dr. Scarlett** |
| | **Dr. Howard** | **Dr.Sharpe** | **Dr. Grice** | **Dr. Braun** | **Dr. Gayeski-Tinkler** |
| **Request Completed (staff initials):** _____ | | **Dr.** _____ | **Dr.** _____ | **Dr.**_____ | **Dr.** _____ |