CAROLINA EYECARE PHYSICIANS, LLC

Once form is completed, please email to info@cepmd.com

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

☐ **Belle Hall**: 805 Long Point Road, Mt Pleasant, SC 29464
P) 843.971.6300 **F)** 843.971.8664

☐ **Charlie Hall Retina:** 2057 Charlie Hall Blvd A. Charleston, SC 29414
P) 843.763.6491 **F)** 843.763.6317

☐ **James Island:** 349 Folly Rd Charleston, SC 29412
P) 843.762.7800 **F)** 843.762.7898

☐ **Mary Ader:** 3531 Mary Ader Ave Ste B Charleston, SC 29414
P) 843.577.2047 **F)** 843.377.2198

☐ **Moncks Corner:** 730 Stoney Landing Road
Moncks Corner, SC 29461
P) 843.899.3393 **F)** 843.769.4200

☐ **Mt. Pleasant:** 1101 Johnnie Dodds Blvd Mt. Pleasant, SC 29464
P) 843.881.3937 **F)** 843.375.1487

☐ **Nexton Medical Plaza:** 5500 Front Street Unit 120Summerville, SC 29485
P) 843.873.5577 **F)** 843.873.5583

☐ S**am Rittenberg:** 1739 Sam Rittenberg Blvd Charleston SC 29407
P) 843.577.2047 **F)** 843.377.2198

☐ **Walterboro:** 459 Spruce Street Walterboro, SC 29488
P) 843.549.9500 **F)** 843.549.6885

☐ **Bluffton:** 10 William Pope Drive Okatie, SC 29909
P) 843.842.2020 **F)** 843.705.1512

☐ **Hilton Head:** 220 Pembroke Drive Hilton Head Island, SC 29926
P) 843.842.2020 **F)** 843.705.1512

☐ **Lady's Island:** 33 Kemmerlin Lane Lady's Island, SC 29907
P) 843.842.2020 **F)** 843.705.1512

☐ **Moncks Corner/Cofield:** 116 N US HWY 52 A. Moncks Corner SC 29461
P)843.577.2047 **F)** 843.377.2198

☐ **Mt Pleasant 2/Mathis Ferry:** 242 Mathis Ferry Road Suite 100.
Mt. Pleasant, SC 29464
P) 843.884.1101 **F)** 843.884.4773

☐ **Murrells Inlet:** 11947 Grandhaven Dr Unit M, Murrells Inlet, SC 29576
P) 843.299.2485 **F)** 843.299.2486

☐ **North Charleston:** 2861 Tricom Street North Charleston, SC 29406
P) 843.797.5511 **F)** 843.797.0638

☐ **Summerville:** 296 Midland Parkway Summerville, SC 29485
P) 843.873.5577 **F)** 843.873.5583

☐ **West Ashley:** 2060 Charlie Hall Blvd., Suite 201, Charleston, SC 29414
P) 843.722.2010 **F)** 843.723.3914

☐ **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. ☐ Copy for northern physician ☐ Insurance Change. New Insurance: _____
☐ Primary physician needs records. ☐ Change of provider. Provider Name: _____ ☐ 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 to process your request.

For Office Use Only	
Release Records of Dr.	Approved by Dr.
Date:	Request Completed By: