CAROLINA EYECARE PHYSICIANS

A US EYE COMPANY

Once form is completed, please fax to the office

Patient Information:

Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

Request Medical Information FROM: ☐ **Carolina Eyecare Physicians** ☐ **Other (Fill in Information Below)**

Physician/Practice Name: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

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

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

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

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

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

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

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

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

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

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

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

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

Sam Rittenberg: 1739 Sam Rittenberg Blvd, Charleston SC 29407
P) 843.577.2047 F) 843.377.2198

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

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

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 (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: _____