



Authorization for Release of Information

By completing this document, you hereby authorize the use or disclosure of your individually identifiable health information, as described below. In executing this authorization, you acknowledge that you do so voluntarily. Unless otherwise stated in our Privacy Notice, you have the right to revoke this authorization at any time.

Patient Name: _____

DOB: _____ **SS#:** _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Requesting Records From : _____

Phone# : _____ **Fax# :** _____

Send Records To : _____

Change of Doctor: _____ **Specialist:** _____ **Other:** _____

For patients transferring records out, there is a \$25.00 charge for printed copies of record.

Authorization Signature: _____ **Date:** _____

I understand that the records and information to be released may contain and include information of a personal and confidential nature. This authorization is subject to revocation at any time by notifying this office in writing. Without revocation, authorization will automatically expire in 90 days from the date thereof.

cmc-pa.com

 [ChildrensMedicalCenterPA](https://www.facebook.com/ChildrensMedicalCenterPA)

 [@CMCGreenville](https://twitter.com/CMCGreenville)

703 Verdae Blvd.
Greenville, SC 29607
Tel: 864.288.5402
Fax: 864.234.7961

3455 Highway 153
Piedmont, SC 29673
Tel: 864.295.8811
Fax: 864.295.0806

307 North Main St.
Simpsonville, SC 29681
Tel: 864.228.8010
Fax: 864.228.8050

841 South Buncombe Rd.
Greer, SC 29650
Tel: 864.877.1220
Fax: 864.877.7731

6527 State Park Rd.
Travelers Rest SC 29690
Tel: 864.610.2108
Fax: 864.610.2900