Records Release Authority

To: ____

____

I, ____, hereby request that you release to:

Dr. Marc N. Dubick
Pain Care & Natural Medicine Center of Charleston
2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, SC 29414
(843) 573-3444 fax: (843) 769-4312

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me.

Request Date: __________________ Expiration Date: ____________, 2020

Patient Signature: ____

Witness: ____

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I understand that I have the right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to the Medical Records Custodian. I understand that the cancellation/revocation will not apply to information, which has already been released in response to this authorization. Unless otherwise canceled/revoked this authorization will expire/end on the above signed date.

I understand that there is a fee for copies of protected health information. The fees to be charged are set by South Carolina law (SC 44-115-80).

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. If I have questions about the disclosure or use of my protected health information I may contact the information Security Officer at (843) 573-3444.

I understand I have the right to receive a copy of this authorization.

I understand that if this information is requested in person I will be asked to provide picture identification (e.g. driver's license). A copy of my identification will be made and attached to this authorization.

______________________________________ ____________________
Signature of Patient Date

______________________________________ ____________________
Office Staff Signature Date