Palmetto Eyecare Associates, P.A.

2460 India Hook Road, Suite 206
Rock Hill, SC 29732
Tel: 803-985-2020

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Date: _________________________

Patient Name: ____

Date of Birth: ____________________________

Address: ____

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Person/Persons Authorized to Release Health Care Information:

Palmetto Eye
2460 India Hook Road
Rock Hill, SC 29732
Phone: 803-985-2020
Fax: 803-985-2021

Person/Persons Authorized to Receive Health Care Information:

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____

Phone: __________________________________

Fax: __________________________________

Statement of Release:

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed below. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, it employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

____ _______________________
Patient or Patient Representative Signature Date

____
Patient or Patient Representative Printed Name