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**

- ☐ **West Ashley:** 2060 Charlie Hall Blvd., Suite 201 - Charleston, SC 29414 – 843.722.2010 Fax 843.723.3914
- ☐ **West Ashley II:** 1637 Savannah Highway – Charleston, SC 29407 – 843.766.3768 Fax 843.769.4200
- ☐ **North Charleston:** 2861 Tricom Street – North Charleston, SC 29406 – 843.797.5511 Fax 843.797.0638
- ☐ **North Charleston II:** 9279 Medical Plaza Drive, Suite D – North Charleston, SC 29406 – 843.884.1011
- ☐ **Mt. Pleasant:** 1101 Johnnie Dodds Blvd – Mt. Pleasant, SC 29464 – 843.881.EYES Fax 843.375.1487
- ☐ **Mt Pleasant/Mathis Ferry:** 242 Mathis Ferry Road – Mt. Pleasant, SC 29464 – 843.884.1101 Fax 843.884.4773
- ☐ **Summerville:** 296 Midland Parkway – Summerville, SC 29485 – 843.873.5577 Fax 843.873.5583
- ☐ **Walterboro:** 459 Spruce Street – Walterboro, SC 29488 – 843.549.9500 Fax 843.549.6885
- ☐ **Moncks Corner:** 730 Stoney Landing Road – Moncks Corner, FL 29461 – 843.899.3393
- ☐ **Georgetown:** 1200 Highmarket Street – Georgetown, SC 29440 – 843.793.5437

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

FOR OFFICE USE ONLY					
Release Approval	**Dr. Boatwright**	**Dr. Herring**	**Dr. Newland**	**Dr. Reuther**	**Dr. Solomon**
Date:	**Dr. Brame**	**Dr. Burger**	**Dr. Folgar**	**Dr. Knowlton**	**Dr. Scarlett**
	Dr. Howard	**Dr.Sharpe**	**Dr. Grice**	**Dr. Braun**	**Dr. Gayeski-Tinkler**
Request Completed (staff initials): _____	**Dr. _____**	**Dr. _____**	**Dr._____**	**Dr. _____**	