AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Midlands Medical Wellness Center, LLC
200 Springtree Dr, Suite 200
Columbia, SC 29223
Phone 803-223-9328
Fax 866-243-4929

I authorize _____ to release my medical information record to Midlands Medical Wellness Center, LLC.

I understand my medical information may be subject to re-disclosure by the recipient and may no longer be protected by law. This practice is not responsible for any re-disclosed information by third party lawfully furnished this information. I understand that I can revoke this authorization at any time by written request.

Patient sign/patient representative sign **date**

Witness **date**

If you signed as patient's representative give description of authority _____

Patient's name_____

Date of birth _____/_____/_____

Social security number_____

Records requested:
____pap smear results
____mammogram report
____PSA results
____history and physical
____lab reports
____problem lists
____medication lists
____Other