



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**Midlands Medical Wellness Center, LLC  
7201 Brookfield Rd.,  
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.

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**Patient sign/patient representative sign** **date**

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**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