Anderson Skin and Cancer Clinic. P.A.

200 Carwellyn Road
Abbeville, South Carolina 29670
1-800-922-7546

2022 Cardinal Circle
Anderson, South Carolina 29621
(864) 224-7577
FAX (864) 225-5165

106 Municipal Drive
Seneca, South Carolina 29672
(864) 882-7747
FAX (864) 882-7760

Authorization for Release of Medical Record Information:

Patient Name: _____ Acct. # _____
(Please Print)

Patient Address: _____
(Street) (City) (State) (Zip Code)

Date of Birth: _____ SSN: _____ Daytime Telephone: (___)_____

Reason for release of medical record information:

- ☐ Consultation/Second Opinion
- ☐ Insurance
- ☐ Cancer or Other Policy
- ☐ Moving Out-of-Town
- ☐ Transfer to Another Physician
- ☐ Personal File

The information to be provided: (Please check all that apply.)

- ☐ History and Physical for _____ (Date of Service[s])
- ☐ Consultation Report for _____ (Date of Service[s])
- ☐ Operative Report for _____ (Date of Service[s])
- ☐ Pathology Report for _____ (Date of Service[s])
- ☐ Progress Note for _____ (Date of Service[s])
- ☐ Lab Report for _____ (Date of Service[s])
- ☐ X-Ray Report for _____ (Date of Service[s])
- ☐ Other: _____ _____ (Date of Service[s])

I hereby authorize _____ to release the above information to:
(Name of Physician)

_____ _____
(Name of Physician or Organization to receive the information.) (Mailing Address of Recipient)

I understand that this Release of Medical Record Information applies only to services provided to me as of the date the Authorization is signed. If I want other information released, I must sign another Authorization for Release of Medical Record Information. This ensures that my medical record information is not provided to any non-claims paying entity without my expressed authorization.

_____ _____
(Date) (Signature of Patient, Parent or Legal Guardian)

_____
(Witness)

_____
(Physician's Signature/Date)

ORIGINAL - Medical Record * YELLOW COPY - Patient's Copy

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