Family Medicine and Mohr

Richard E. Mohr III, MD

1505-A Heritage Lane, Florence, SC 20505

(O) 843-407-9010 (F) 844-629-6711

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____Date of Birth: _____

REQUESTING RECORDS FROM:

Practice/Physician: _____

Phone:_____

Fax: _____

The information you may release subject to this signed release form is as follows:

___Complete Records	___History & Physical	___Progress Notes
___Care Plan	___Lab Reports	___Radiology Reports
___Pathology Reports	___Treatment Plan	___Operative Reports
___Hospital Reports	___Medication Records	___Other (please specify below)

The purpose/reason for this release of information is as follows:

_____

RECORDS TO BE RELEASED TO:

Family Medicine and Mohr
Richard E. Mohr III, MD
1505-A Heritage Lane, Florence, SC 29505
Phone: 843-407-9010
Fax: 844-629-6711

Signature:

_____ _____
Patient Name — Signature of Patient or Personal Representative

_____ _____
Patient Date of Birth or SSN — Printed Patient Name or Personal Representative

_____ _____
Date — Description of Personal Representative's Authority