Coastal Carolina Allergy & Asthma Associates, PC
Mark H. Schecker, MD
3516 Caduceus Drive
Myrtle Beach, Sc 29577
Phone 843-293-0093 Fax 843-293-0096

Authorization for Use or Disclosure of Protected Health Information

PATIENT:

Patient's Name: _____ Chart# _____

Date of Birth: _____ SS# _____

Dates of Treatment: _____

AUTHORIZATION:

I, _____ give authorization to Coastal Carolina Allergy & Asthma Associates, PC to Release/Disclose the above named individual's health information. I understand this authorization is voluntary. No individual has coerced me into signing this Authorization; I am providing this authorization under my own free will.

THE INFORMATION TO BE DISCLOSED IS AS LISTED:

____ Physician Notes ____ Entire Record

____ Lab Reports ____ XRAY Reports

____ Other, Please specify information and dates _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above.

INFORMATION IS TO BE RELEASED TO:

Name: _____
Address: _____

____ Patient requests records be faxed to another facility or physician's office. Patient is aware (pt initial above) of confidentiality risks involved and releases Mark H. Schecker, MD of responsibility of this fax.

PURPOSE:
The purpose for the release of this information is:

____ Insurance or other Third Party Reimbursement

____ Continuity of Medical Care

____ Pending legal action

____ Other (Specify) _____

DURATION:

This authorization will remain valid for 90 days from date of signing. The individual executing this authorization has the right to revoke this authorization at any time and he/she must do so in writing. The revocation will not apply to information already released. The revocation will not apply to his/her insurance company when the law provides the insurer with the right to contest a claim under their policy.

SIGNATURE:

Patient's Signature: _____

Person/Legal Representative's Signature: _____

(Relationship to Patient) _____

Today's Date: _____

PROVIDE A COPY OF THIS SIGNED FORM TO THE PATIENT OR PERSONAL/LEGAL REPRESENTATIVE.

This release expires six months from date signed.

Dr. Mark H. Schecker
Allergist

Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

I HEREBY AUTHORIZE AND REQUEST

_____

_____

_____

TO RELEASE MY RECORDS TO:

DR. MARK H. SCHECKER
3516 CADUCEUS DRIVE
MYRTLE BEACH, SC 29588

843-293-0096 FAX

Patient Name _____

Date of Birth _____

Signature _____

Date _____

This request expires six months from date signed.