



# Internal Medicine Associates of Greenville, PA

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## MEDICAL RECORD RELEASE REQUEST

### Internal Medicine

William R. Craig, III, MD, FACP  
Peter S. Maurides, MD  
Steven L. Graddick, MD, FACP  
Robert D. Bayliss, Jr., MD  
D. Bryan Worthington, MD, FACP  
Sheila A. O'Grady-Irwin, MD, FACP  
Daniel A. Grover, MD  
Andrew G. McDonald, MD  
Tony S. Poteat, Jr., MD  
James R. Bloodworth, Jr., MD  
David W. Koontz, MD  
Amy Z. Welcome, MD  
Robert M. DuBose, III, MD  
Jai W. Hwang, MD  
Thomas V. Chambliss, MD  
Caroline D. Brownlee, MD  
Ronald P. Lindamood, MD  
David P. Guirao, MD  
Jonnie L. Greene, FNP  
Elizabeth B. Meyer, FNP

### Cardiovascular

Francis T. Thandroyen, MD, FACC

### Surgery

Daniel M. Jacques, MD

### Gastroenterology

Ali M. Yazdy, MD  
Lawrence J. Hartley, Jr., MD  
Sumodh C. Kalathil, MD  
Navid Madani, MD  
Sally D. Baranski, FNP  
Theresa Economou, ANP  
Amanda B. Couch, FNP-BC

### Rheumatology

Allison S. Lipsey, MD

### Endocrinology

Mojgan Rahmani, MD, CDE, FACE

### Managing Partner

Peter S. Maurides, MD

### Administration

Carmel T. West

PATIENT NAME: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # \_\_\_\_\_

*The following person or facility is authorized to provide copies of the patient's identifiable health information:*

RELEASE FROM: NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

SEND TO: NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

#### Purpose for releasing the information:

Moving Away from Area  Transfer of Care  At request of Patient  For Patient Care

#### Describe the information that is to be released:

Office / treatment notes  Lab Reports  X-ray /CT reports  EKG  
 Other: \_\_\_\_\_

#### Indicate the dates of service that is to be released:

Entire medical records for services rendered at this office.  
 Last office visit, laboratory and/or x-ray test results  
 Other (please specify): \_\_\_\_\_

I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.

I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. *Note: The revocation must be in writing and delivered to the above address of the person/entity of whom was to release information.*

I understand that unless earlier revoked, this authorization will expire 30 days after the date signed.

I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the medical records department.

I understand that I have the right to obtain a copy of this authorization.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Or Legal Representative of Patient: \_\_\_\_\_  
(Attach legal Representative Document) DATE \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE \_\_\_\_\_

[OFFICE USE: DATE RECORDS SENT: \_\_\_\_\_ BY: \_\_\_\_\_]