PALMETTO CARDIOLOGY OF YORK CO.

HARRY E. HICKLIN III MD
430 S HERLONG AVE, STE 104
ROCK HILL, SC 29732

Authorization to release/receive medical records

___________________________________ ____________________________
(Patient Name) *(Date of Birth)*

___________________________________ ____________________________
(Address) *(Phone)*

___________________________________ ____________________________
(City/State) *(Zip)* *(Phone) - Work*

___________________________________ ____________________________
(Medical Record Number) *(Social Security Number)*

I do hereby authorize __________________________________ to release or obtain all medical records pertaining to my care **AND** permit a photocopy of this authorization to be used as the original.

_______Please release last 3 office notes, most recent heart catheterization report and medication list.

_____**I Also Authorize** release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency) Infection, psychiatric care, psychological assessment and treatment from alcohol and /or drug abuse.

I understand that I have the right to revoke this authorization at any time as well as to inspect or copy the protected information to be disclosed as described in this document by sending a written notification to Palmetto Cardiology of York County. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse signing of this authorization and that my treatment will not be conditioned on signing or not signing this authorization. This authorization shall remain in force until revoked by the patient or representative signing this authorization.

Please check one of two methods below:

_______*Mail To*: Dr. Harry Hicklin
Palmetto Cardiology of York County
@ 430 S. Herlong Avenue, Suite 104
Rock Hill, SC 29732
Or
______Fax: #803-324-1155

Reason for request: Continuation of Care

*Signature (Full name of Patient, Legal Guardian, or POA*_________________________________

____ ___________________
Witness *Date*