Cross Island Medical Center

Phone: 843-681-8260
Fax: 843-342-6210
157 William Hilton Parkway
Hilton Head Island, SC 29926

Consent for Release of Confidential Patient Information Form

1. This will authorize: _____

(Facility/Individual Releasing Information)

Mailing Address: _____

_____

2. To release the following information

( ) Complete Medical Records
( ) Other: _____

To: _____

(Facility/Individual Receiving Information)

3. For the following:

( ) Insurance Claims
( ) Physician Referral
( ) Workers Compensation
( ) Other: _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. This consent will expire in 45 days from the date signed. I understand that I have the right to examine and copy the information to be disclosed.

To Receiving Party: This information has been disclosed to you for the sole purpose stated in the consent. Any other use of this information without written permission from the patent is prohibited. Federal Regulation (42 CFR, Part 2), may protect these records.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent / Guardian: _____ Date: _____