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- 1029 West Meeting Street  
Lancaster, SC 29720
- 902 West Meeting Street  
Lancaster, SC 29720
- 1609 Constitution Blvd.  
Rock Hill, SC 29732

- For questions call 803-285-2041  
fax 803-285-2097
- For questions call 803-274-6070  
fax 803-285-2097
- For questions call 803-366-8300  
fax 803-327-4805

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

\_\_\_\_\_ SSN# \_\_\_\_\_

I hereby authorize CHS to: \_\_\_\_\_ Obtain records from (or) \_\_\_\_\_ Release records to:

FACILITY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX: \_\_\_\_\_

\_\_\_\_\_ MAIL FAX PICK UP  
(CIRCLE ONE OF THESE)

DATES OF SERVICE AND SPECIFIC INFORMATION REQUESTED:

\_\_\_\_\_

IF WE ARE RELEASING YOUR RECORDS -THERE IS A COPYING FEE.

PURPOSE OF RELEASE OF RECORDS:

- Continuing Treatment  Personal  Staff/Physician Issue
- Legal Investigation  Change in Ins.  Disability Determination
- Worker's Comp.  Moving  Other \_\_\_\_\_

I hereby release you from all legal responsibility that may arise from this authorization.

Sensitive Information: I understand that my record may include information relating to acquired immunodeficiency syndrome (AIDS), or HIV (Human Immuno-deficiency) Infection, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing & that the revocation will not apply to info already released based on this information.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition (If I do not specify an expiration date, event, or condition, this authorization will expire in twelve months.)

\_\_\_\_\_  
Signature of Patient or Legal Representative Date Expiration Date