South Carolina Sports Medicine & Orthopaedic Center

Seth P. Kupferman, MD
Orthopaedic Surgery
Sports Medicine

James D. Dalton, Jr., MD
Orthopaedic Surgery
Sports Medicine

Jon P. DeVries, MD
Orthopaedic Surgery
Hand Surgery

George Pappas, MD, PhD
Orthopaedic Surgery
Hand Surgery

John T. Hulvey, Jr., MD
Primary Care Physician
Sports Medicine

Michael R. Byers, PA-C
Licensed Physician Assistant
Certified Athletic Trainer

Sarah J. Burkhart, PA-C
Licensed Physician Assistant
Certified Athletic Trainer

Consent to Release/Disclose Patient Records/Medical Information

Please Print ALL Information Unless Otherwise Noted

Patient's Name: _____ Date of Birth: _____
Address, City, State, & Zip Code: _____
Patient's Phone Number: _____

Requesting my protected health information from the following physician/facility:

South Carolina Sports Medicine & Orthopaedic Center
9100 Medcom Street N. Charleston, SC 29406
Phone: **843-572-2663** Fax: **843-377-4012**

By signing this form, I am requesting and authorizing you to release and transfer all confidential health information about me to the physician/ person/ facility listed below.

Release my protected health information to the following physician/ person/ facility:
Name: _____
Address, City, State, & Zip Code: _____
Phone Number: _____ Fax Number: _____

For the following dates or specific injury:
_____

- For records released directly to the patient there is a charge of:
  $15.00 Handling Fee
  $0.65 per Page for 1st 30 pages (then, $0.50 per Page thereafter)
- I understand this authorization will automatically expire one year from the date signed, but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and receive a copy of the information that is to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be able to provide me with the most appropriate care.
- I understand that the release of information may NOT be re-released to any other person or organization, without my written consent.

_____ _____
Print Name of Patient or Personal Representative Date

_____
Signature of Patient or Personal Representative

**When do you need the records? Date:_____