THE HICKEY WELLNESS CENTER
Dr. Joseph T. Hickey
30 NEW ORLEANS ROAD
HILTON HEAD, SC 29928
843-842-9960
843-842-9963 (Fax)

AUTHORIZATION TO OBTAIN INFORMATION

I, or my legal representative, hereby AUTHORIZE any health care provider, hospital, laboratory, health plan, or health care clearinghouse, to release any and all medical and non-medical records and information in its possession about me to **Dr. Joseph Hickey /The Hickey Wellness Center** or it's representative. Health care provider, includes, but is not limited to: physician, physician assistant or nurse practitioner, medical professional, hospital, clinic, pharmacy, laboratory, insurance or reimbursing company, the MIB (Medical Information Bureau).

Information to be disclosed:

____X__ Complete Health Records _____ Discharge Summary _____X-Ray Reports

_____ History & Physical Exam _____ Progress Notes _____ Consultation Notes

_____ Photographs, Videos, digital or other images _____Laboratory Reports

_____ Other (Please specify) _____

1. 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.
2. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent in writing to the address noted at the top of the form.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
4. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.
5. I understand that a copy or FAX of this document is just as valid as the original document.
6. I understand that this authorization will be in effect until I provide written notice to revoke it.

By signing this form, I agree to allow Dr. Joseph Hickey, or representative of his medical office to obtain my medical records.

_____ _____
Print Patient Name Patient/or legal representative

_____ _____
Patient Date of Birth Last 4 digits of Social Security #

_____
Date